Department of Human Services
Med-QUEST Division

Community Integration Services Plus (CIS+)
Action Plan
(Appendix E)

Part 1: Agency Information

CIS+ Agency:	Medicaid Provider ID:	
Interviewer Name and ID (If applicable):	Date Initiated:	Date Completed:

Part 2: Member Information

Member First Name:			Member Last Name:	Middle Initial:
Medicaid ID #:			Birthdate:	Age (Years):
HMIS ID #: ☐ Unknown ☐ Not in HMIS		Medicaid Redetermination Date:	Other Relevant IDs (VA, etc.) (specify):	Other ID Number(s):
Current Residential Address/Location:				
Street or Location:			City:	Zip Code:
Mailing Address (if different from current address)				
Street:			City and State:	Zip Code:
Contact Information	Phone Number	Can receive texts?	Email Address:	
	1.	Yes ☐ No ☐		
	2.	Yes ☐ No ☐		
Any friends or family who can help reach you? Yes ☐ No ☐ If yes, Contact Name:			Contact Phone Number:	Relationship to Member:

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Read to member: I am going to ask you some questions about your health, well-being, housing history, and access to resources. This will help us understand what is important to you and find out which services best suit your needs. You do not have to answer a question if you don't want to.

Part 3: Member Health and Well-Being

1. In general, would you say that your health is:	☐Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
2. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?				Number of Days _____	
3. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?				Number of Days _____	
4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing usual activities, such as self-care, work, or recreation?				Number of Days _____	

Part 4: Member Housing

5. In the last 30 days, how many days have you lived (enter number of days):	Outside (e.g., street, car, camper/RV or park) _____ days	at an emergency shelter _____ days	at a temporary/transitional shelter _____ days	in a supervised group home _____ days	in a shared apartment _____ days	in an independent apartment _____ days
6. Do you have any new accessibility needs?	☐ Yes*	☐ No	*6a. If yes, what are your accessibility needs?			
7. Are you currently housed? Yes ☐ No ☐	If **yes**: 7a. What type of housing: ☐ Permanent ☐ Temporary/Transitional ☐ Institutional ☐ Other 7b. Are you newly housed since the last assessment: Yes ☐ No ☐			If **no**: 7c. Have you lost housing since last assessment: Yes ☐ No ☐		
8. If receiving **Tenancy Sustaining Services**: Are you satisfied with your current housing? Yes ☐ No ☐	*8a. If no, what are your concerns?					

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Part 5: Services/Resource Utilization

Services/Resources	Member NEEDS this service	CIS+ Provider will support member in accessing this resource in the next 90 days	Member not interested in this service at this time
HOUSING			
CIS+ Medical Respite Benefits			
1. CIS+ Short-Term Pre/Post-Procedure Housing (for a planned procedure/treatment)	☐	☐	☐
2. CIS+ Short-Term Recuperative Care (up to 90 days)	☐	☐	☐
3. CIS+ Short-Term Post-Hospitalization housing (up to 6 months)	☐	☐	☐
Other Housing Assistance *(Outside of Medical Respite)*			
4. Housing documents; ID assistance	☐	☐	☐
5. Rental housing access (rental information, applications, etc.)	☐	☐	☐
6. Emergency shelter	☐	☐	☐
7. Temporary/transitional housing	☐	☐	☐
8. Housing accessibility support	☐	☐	☐
9. Permanent/long-term housing	☐	☐	☐
10. Landlord mediation/advocacy	☐	☐	☐
11. Development of/changes to eviction prevention plan	☐	☐	☐
12. Ongoing housing subsidies/vouchers	☐	☐	☐
HEALTHCARE			
13. Accessing medical services; vision; nutrition/dietitian, dental; primary care	☐	☐	☐
14. Accessing mental health services and social supports; crisis services	☐	☐	☐
15. Substance abuse treatment services	☐	☐	☐
16. Compliance with Medical/Mental Health/Substance Use Plan of Care and medications	☐	☐	☐

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HEALTH COORDINATION			
17. Health Coordination by Health Plan *If member needs or refuses health coordination, refer to Health Plan for review*	☐	☐	☐
OTHER SERVICES			
Social Services			
18. Securing/maintaining Medicaid eligibility	☐	☐	☐
19. Benefits services, including TANF, SSI and SSDI	☐	☐	☐
20. Accessing food benefits, including WIC and SNAP	☐	☐	☐
21. Accessing food/necessities; soup kitchen or food pantry; cooking	☐	☐	☐
22. Legal assistance; probation; parole	☐	☐	☐
23. Clothes closet	☐	☐	☐
24. Day center with telephones, mailrooms, or restrooms	☐	☐	☐
Financial/Employment Assistance			
25. Budgeting assistance/money management; establishing credit; financial counseling	☐	☐	☐
26. Job readiness, job search, or employment assistance, vocational services; education, volunteer supports	☐	☐	☐
Other Resources			
27. Transportation assistance	☐	☐	☐
28. Individual and/or family counseling, skills coaching; support groups, natural supports, anger management/domestic violence/AA-NA	☐	☐	☐
29. Caregiving for children and other relatives	☐	☐	☐
30. End of life planning	☐	☐	☐
31. Personal care (long-term support services)	☐	☐	☐

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Part 6: Person-Centered Housing Goals

32. What are your **housing** goals (short-term and long-term)? **(Complete during initial assessment. Review and revise as needed quarterly)**
a.
b.
c.
d.

Part 7: Other Interviewer Notes and Observations:

33. CIS+ Assessment completed: Yes ☐ No ☐
34. Notes:
35. If this is an update to an existing CIS+ Action Plan, what progress has been made since the last CIS+ Action Plan was completed?

Part 8: Discharge from CIS+:

36. Is member exiting CIS+? Yes ☐ No ☐	If yes, why is the member exiting CIS+? (Select all that apply) ☐ Obtained stable housing; no longer needed services ☐ Transitioned to a higher level of care (e.g., nursing facility, inpatient behavioral health, incarcerated) ☐ No longer eligible for CIS+ ☐ No longer eligible for Medicaid ☐ Voluntary disenrollment ☐ Lost to follow up ☐ Deceased	*If yes, what type of housing is the member exiting to/remaining in? ☐ Permanent ☐ Temporary/Transitional ☐ Institutional ☐ Place not meant for habitation (e.g., car, beach, street, park, etc.) ☐ Unknown ☐ Other (Deceased, Relocated out of state) _____ Date of Discharge *(mm/dd/yyyy)*:

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Signatures

This information was collected in good faith and is as accurate as possible:

Member Signature	Member Advocate Signature (if applicable)	Date
CIS+ Interviewer Signature	CIS+ Interviewer Name and Title	Date