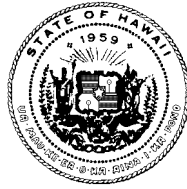


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April 1, 2021

MEMORANDUM

MEMO NO.

QI-2105

CCS-2102

TO: QUEST Integration (QI) Health Plans
Community Care Services (CCS) Health Plan

FROM: Judy Mohr Peterson, PhD *JMP*
Med-QUEST Division Administrator

SUBJECT: COMMUNITY INTEGRATION SERVICES (CIS) IMPLEMENTATION GUIDELINES:
OVERVIEW, MEMBER ELIGIBILITY, SERVICE DELIVERY, COORDINATION, &
REIMBURSEMENT

Introduction

Supportive Housing is an evidence-based practice¹ that combines affordable housing with supportive services that help eligible individuals access housing resources and remain successfully housed.

Community Integration Services (CIS)-Supportive Housing Services are the Medicaid reimbursable supportive services available to eligible QI members, that when paired with affordable housing,² are a cost-effective way to engage members experiencing homelessness, help reduce homelessness and increase housing stability. CIS funds

¹ The U.S. Department of Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes supportive housing as an evidence-based practice and has developed toolkits for program fidelity that can be found here: <https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509>

² The U.S. Department of Housing and Urban Development (HUD) defines affordable housing as "Housing for which the occupant is paying no more than 30 percent of his or her income for gross housing costs, including utilities." Taken from the HUD Glossary of Community Planning and Development Term. https://www.hud.gov/program_offices/comm_planning/library/glossary/a

supportive housing services including pre-tenancy and tenancy support services intended to help members attain and maintain safe affordable housing; CIS does not cover most housing expenses. Most importantly, CIS seeks to engage the member in self-care and personal management by establishing a personalized housing support plan that is holistic and reflective of his or her preferences and goals. CIS assists eligible QUEST Integration (QI) members with becoming fully integrated members of the community as well as achieving improved health outcomes and life satisfaction. The list of CMS approved CIS benefits are included in Appendix A.

The Community Care Services (CCS) behavioral health plan is responsible for providing CIS for CCS members. All other QI members will receive CIS through their QI health plan.

Eligibility Criteria

Any QI eligible member who is homeless or is at risk of becoming homeless can be referred to the member's QI health plan to receive a CIS screening. There are no restrictions on who can make the referral. The DHS is expecting referrals to come from a variety of sources including but not limited to self or family members, homeless services providers, other community-based organizations, and healthcare providers.

CIS benefit eligibility criteria include being age **18 years or older** and:

1. **Member meets at least one of the following health needs-based criteria** and is expected to benefit from CIS:

- a. Individual assessed to have a behavioral health need which is defined as one or both of the following criteria:
 - i. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the **presence of a serious mental illness**; and/or
 - ii. Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1 indicating the need for intensive outpatient treatment for a Substance Use Disorder (SUD)

OR

- b. Member assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).

AND

2. Member has at least one of the following risk factors:

- a. Homelessness, defined as lacking a fixed, regular, and adequate nighttime residence, meaning:
 - i. Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; or
 - ii. Living in a supervised publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals).

OR

- b. At risk of homelessness, defined as an individual who will lose their primary nighttime residence:
 - i. There is notification in writing that their residence will be lost within 21 days of the date of application for assistance;
 - ii. No subsequent residence has been identified; and
 - iii. Does not have enough resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter; or
 - iv. History of frequent and/or lengthy stays in an institution.
 1. Frequent is defined as more than one contact in the past 12 months.
 2. Lengthy is defined as 60 or more consecutive days within an institutional care facility.

QI Health Plan Roles and Responsibilities

The Health Plan shall develop and implement its CIS program, per guidance specified below, no later than July 1, 2021.

1. Identification of Potential CIS Members

Referrals for CIS will come through different entities, depending on where the member is engaged and/or identified as potentially eligible for CIS. QI Entry points into CIS include:

- a. QI health plan data analyses for Homelessness Z-Code (Z59 series), or other indications of homelessness (e.g., Z55-Z65 series used to document persons with potential health hazards related to socioeconomic and psychosocial circumstances,

- and other indicators of unusual utilization patterns or address information indicative of housing instability);
- b. QI health plan analyses of utilization data on members who are identified to be homeless or potentially homeless to establish health needs-based criteria;
 - c. QI health plan members who were previously identified as homeless or at risk for homelessness but were assigned a status of H7 (CIS – Beneficiary Lost to Follow Up) or H8 (CIS – Unable to Contact) and subsequently disenrolled from the program;
 - d. Access to and verification of homelessness status within the Homeless Management Information system (HMIS). MQD encourages Health plans to establish data sharing agreements with HMIS that enable automated member-matching;
 - e. Member-matching against the HMIS/Coordinated Entry System (CES) By-name-list;
 - f. Welcome calls for new members/member surveys- from QI health plan activities;
 - g. Quality improvement activities through QI health plan;
 - h. HFA assessments/re-assessments for QI members or other member engagement activities;
 - i. Referrals from Community Service Coordinators/Case Managers, or other healthcare providers;
 - j. Referrals from current homeless agencies, independent living providers, DHS and Continuum of Care (CoC) Homeless Assistance Agencies, Hawaii Public Housing Authority, Department of Health’s (DOH) Alcohol and Drug Abuse Division (ADAD) and Adult Mental Health Division (AMHD);
 - k. Medical provider referrals, including but not limited to providers from inpatient, emergency department, nursing facility, primary care, community health centers, other clinical, and other institutional settings;
 - l. Referrals from MQD Medicaid eligibility workers, and other MQD staff;
 - m. Re-entry worker/system referrals for example from the Hawaii State Hospital (HSH), prisons, drug treatment facilities, etc.; and
 - n. Members, or their friends and family members.

2. **CIS Referral and Eligibility Confirmation**

The **CIS Referral Form** is provided in Appendix B. Given multiple points of entry into CIS, completion of the CIS referral form is not mandatory; rather, the form is provided as a tool to enable standardized data collection from community-based referral sources. Additionally, while MQD does not require CIS Referral Form to be completed, QI Health plans must make arrangements to electronically capture the referral/identification source on all CIS beneficiaries, as these data shall be included among required reporting elements.

CIS referral forms shall be sent to the member’s QI health plan or to MQD/HCSB if member’s QI health plan is unknown. MQD will forward any CIS referral forms received to the member’s current QI health plan. Referrals should be as complete as feasible before submission to the QI health plan; however, referring parties should be encouraged to

submit the referral form and any available documentation regardless of the availability of complete information. It is the QI health plan's responsibility to obtain and assure completeness of information and documentation to confirm eligibility for CIS.

Upon referral notification, the QI health plan will independently verify that the member meets eligibility criteria. *If the member is identified to be in immediate danger, or is currently a threat to self or others, the QI health plan shall take immediate action to provide resources to stabilize the members, regardless of eligibility for CIS.*

For any new external referrals received, the QI health plan shall have 15 days from the receipt of the referral to review documentation, obtain any missing information either from the referring party or from other sources, make a determination as to whether the member meets or fails to meet eligibility criteria for CIS, and provide its decision to the referring party. The QI health plan is referred to diagnosis criteria for CCS for a presumptive definition of Serious Mental Illness (SMI); however, the QI health plan shall use discretion to potentially confirm eligibility of members who do not strictly meet CCS diagnostic criteria, but still may be classified as having SMI. If the QI health plan concludes that the member does not meet eligibility criteria for CIS, the referring party must be provided information on how to appeal the decision. The QI health plan shall incorporate a protocol for how CIS appeals by providers and members shall be reviewed and addressed into its overall member and provider grievance and appeals processes.

In addition to receiving referrals, as noted earlier, Health plans are expected to identify potentially eligible CIS beneficiaries through the new member welcome calls/surveys, as well as through data analytics at least once per quarter. Data analytics includes QI members who were previously at any stage of CIS, and eventually disenrolled from the program (especially when disenrolled due to lack of contact); therefore, if any of these members are re-identified to continue to be eligible for CIS, they shall be re-assigned a status code of H1 (CIS – Potentially Eligible). Additionally, referrals from other QI health plan staff are expected to be received and evaluated on an ongoing basis. New members identified as potentially eligible for CIS through any internal source, including QI health plan analytics, shall be deemed to be eligible or ineligible for CIS within 30 days upon receipt of the referral.

The QI health plan shall develop a plan to process and clear the backlog of any existing referrals in its systems at the start of implementation, including prioritizing members with more complex physical or behavioral health needs using a risk-based algorithm or other predictive analytics tool. The QI health plan's backlog and plan, including timeline, for clearing any backlogs of existing referrals, shall be described as part of CIS reporting requirements, which shall be outlined in a subsequent memorandum that MQD shall release.

Members are considered to be in status H1 (CIS – Potentially Eligible) when they have been referred or otherwise identified through any method as being potentially eligible for CIS services. As the QI health plan confirms eligibility or ineligibility of the member for CIS, the member's CIS status shall be updated to H2 (CIS – Contacted – Confirmed Eligible) or H3 (CIS – Contacted – Not Eligible).

3. **CIS Member Consent**

The **CIS Member Consent Form** is provided in Appendix C. Once a member is deemed eligible for CIS, the QI health plan shall contact the member and obtain consent to participate in the program. In the consent form, an appropriate CIS outreach coordinator, either from the QI health plan or CIS provider, shall confirm the eligibility criteria and obtain current member demographics that support service delivery. For new external referrals submitted by a CIS provider, it is expected that the CIS provider would also complete the consent process. In all other cases, and when a QI health plan staff person does not complete the consent process, a CIS provider shall be prior authorized to complete the consent process.

As part of the consent process, the CIS outreach coordinator shall explain the program and services, provide the member an opportunity to ask any questions, and provide adequate information to support the member in making an informed choice. The member shall be invited to engage any additional advocates of their choosing to participate in consent, assessment, and/or planning process. *If during the consent process, the member is identified to be in immediate danger, or is currently a threat to self or others, the QI health plan shall take immediate action to provide resources to stabilize the members, regardless of the member's consent to participate in CIS.*

Execution of the consent form shall transition a member's CIS status from H2 (CIS – Contacted – Confirmed Eligible) to H5 (CIS – Housing Pre-Tenancy). The QI health plan or CIS provider shall have ten (10) business days after the QI member moves into H2 (CIS – Contacted – Confirmed Eligible) to locate and meet with QI member to obtain consent for CIS. Members who refuse to provide consent to participating in CIS shall be transitioned to a CIS status of H4 (CIS – Contacted – Eligible Refused). The QI health plan shall electronically capture all information on the consent form for reporting to MQD.

4. **CIS Member Assessment and Re-Assessment**

The **CIS Member Assessment/Re-Assessment Tool** is provided in Appendix D. This tool is a modified version of the "Housing Case Management Assessment Tool" currently in use by the CIS provider community. The purpose of the tool is to collect systematic self-reported health information and document various housing and related needs from members enrolled in CIS, along with observations by the assessor, to support identification of social and other clinical needs at the point of care. The tool has two sections:

- a. Section A: Member Self-Assessment where the assessor will administer questions to the member and note down their responses. The member, and member advocate if applicable, will sign to attest to the information provided in Section A.
- b. Section B: The interviewer will conduct an independent assessment of the member. As part of Section B, the interviewer shall score the member's responses, and independently assess and score member acuity. Both scores (Member Assessment Acuity Score and Interviewer Assessed Acuity Score) shall be used to prioritize members for tenancy services.

The same tool shall be used for initial assessment and subsequent reassessments. The health plan or CIS provider shall have fifteen (15) days after the date of consent to assess members newly enrolled in CIS; MQD encourages but does not require health plans/CIS providers to complete the assessment immediately upon completion of the consent process. The assessment/re-assessment will be completed by a CIS Provider and submitted to the health plan. A re-assessment shall be conducted every three (3) months.

Health plans shall be required to submit data collected in both sections of the CIS Member Assessment Tool as part of reporting requirements. Therefore, the tool provided in Appendix D may be operationalized as health plans see fit to ensure data collection that enables reporting to MQD.

If during the assessment or reassessment process, the member is identified to be in immediate danger, or is currently a threat to self or others, the health plan shall take immediate action to provide resources to stabilize the members, regardless of the member's prioritization or acuity score to receive CIS services.

5. **Other CIS-Related Assessments**

Some community providers may also complete the Vulnerability Index-Service Prioritization Decision Assistance Tool or VI-SPDAT. This assessment should be included in the CIS member assessment process for members eligible for the Homeless Management Information System (HMIS) and Coordinated Entry Services (CES).

The health plan shall review the member eligibility and/or assessment/reassessment to identify CIS members who may additionally benefit from Long-Term Services and Supports (LTSS), Special Health Care Needs (SHCN) services, and Community Care Services (CCS). If any of these needs are identified, the health plan will arrange for these additional assessments to be completed.

6. **CIS Health Action Plan Addendum**

The **CIS Health Action Plan Addendum** shall capture the services needed and plan for provision of these services to the member. The CIS Health Action Plan Addendum is

provided in Appendix E. The CIS Health Action Plan Addendum may be used as a stand-alone document to plan CIS services for members who do not need additional Health Coordination Services. For members newly enrolled in CIS, the health plan or CIS provider shall have a total of thirty (30) days from the completion of the initial member assessment to complete the CIS Health Action Plan Addendum. The plan must be reviewed with, agreed to, and signed by the member and preparer before it is considered final. The CIS Health Action Plan Addendum shall be reviewed and updated every three (3) months.

Planning shall be a person-centered process, and the results of the assessment/re-assessment shall guide the development of the CIS Health Action Plan Addendum. CIS service planning shall be conducted with the member and shall develop plans to provide the CIS services and supports corresponding to needs identified in the assessment/re-assessment in the following categories:

- a. Housing supports, including completion of any housing assessments needed for housing placement
- b. Medical supports
- c. QUEST and other DOH program supports
- d. Safety supports
- e. Social Determinants of Health-based supports
- f. Financial assistance and/or supports
- g. Employment and housing readiness supports
- h. Any other supports not identified/categorized elsewhere

The types of supports identified should be person-centered, and additionally reflect the goals of the CIS program, which are to improve health outcomes and decrease healthcare costs of members with complex health needs that are compounded by homelessness or housing instability. As such, re-engagement in medical care, and supports to stabilize and/or fortify the member's ability to manage their health are critical to achieving the goals of CIS. Also, CIS members are particularly vulnerable to losing Medicaid eligibility during re-determination due to incomplete or current contact information and non-submission of required documentation. As a result, the CIS Health Action Plan Addendum shall include CIS Provider actions to support the member in preventing lapses in Medicaid eligibility tied to logistical, as opposed to valid, reasons.

The CIS Health Action Plan Addendum shall additionally address identified barriers and member goals; supports needed for the member to find housing, live successfully in the community and achieve the highest level of independence; services provided by CIS and services provided by community-based resources; and frequency/duration of planned services with the member.

Person centered CIS Crisis Plan and Eviction Prevention Plan: In addition to the CIS Health Action Plan Addendum, the health plan shall also create crisis plans and eviction prevention plans with members enrolled in CIS. MQD encourages health plans to work together to develop a standard approach for crisis and eviction prevention planning that include:

- a. Behaviors or situations that may threaten housing or health, based on past experiences.
- b. Actions the member-tenant will take to prevent or avert a crisis or eviction.

Crisis plans must be completed for all CIS members. Eviction prevention plans shall be in place for members in tenancy status (CIS status code H6 (Beneficiaries in Tenancy)).

7. **CIS Packet**

The "CIS Packet" shall comprise the CIS Consent Form, CIS Assessment/ Reassessment, any other CIS-related assessments completed on the member, CIS Health Action Plan Addendum, crisis plan, and eviction prevention plan (as applicable). The CIS Packet shall be submitted by the CIS provider directly to member's health plan. A copy of the CIS Packet shall be maintained by the health plan. The CIS provider shall also maintain a copy and make a copy available to the member for review upon request. Additionally, the CIS Packet shall be shared with the member's Primary Care Provider and care team (if applicable). If the member is in CCS, the packet shall also be shared with the member's QI health plan. CIS Packet items (specifically, the member re-assessment and CIS Health Action Plan Addendum) shall be reviewed and updated with CIS members every three (3) months, at a minimum.

The CIS Referral Form and the individual forms that make up the CIS packet shall be completed within the various maximum timeframes as detailed in section 2 through section 6 above. MQD encourages health plans to take steps to have these various forms completed sooner than the stated maximums. To that end, and where possible, health plans are encouraged to have multiple forms completed during a single member visit.

Pre-tenancy and tenancy sustaining services to be provided are based on the member's CIS Health Action Plan Addendum and may not be provided or billed prior to receipt of an authorization for service. Information on services and supports authorized via the CIS Health Action Plan Addendum as well as progress on the provision of these services shall be captured electronically by the health plan and submitted to MQD as part of reporting requirements.

8. **Prior Authorization for CIS Pre-Tenancy and Tenancy Services**

Health plans will review and approve the CIS Packet, then authorize CIS pre-tenancy and tenancy services as necessary in three (3)-month increments. The health plan is responsible for ensuring that rules of conflict-free case management are followed and that CIS service

providers for the individual must not also provide case management or develop the CIS Health Action Plan Addendum for the same individual. When the health plan assigns a CIS provider to obtain consent, geography, participant preference and alignment with participant needs shall be considered. Prior authorization turnaround times shall align with standard utilization management turnaround times of 14 days for routine request and 72 hours for urgent requests. Health plans shall develop templates for utilization management reviews that will be shared with MQD and CIS Providers. Health plans are encouraged to work together to collaboratively develop these templates and develop similar processes between plans for ease of development for the health plans and to minimize provider abrasion on the CIS provider network.

The health plan and CIS provider shall work together to coordinate and link the member to QI benefits and providers including needed primary care, health homes and home and community-based services; substance use treatment providers; mental health providers; medical, vision, nutrition and dental providers; crisis services; end of life planning; and needed Medicaid eligibility assistance. The health plan shall subcontract/delegate services to CIS providers to the greatest extent possible. CIS provider shall coordinate and link the member to education, vocational rehab, employment and volunteer supports; other support groups and natural supports; food stamps; financial supports and legal services as needed. The health plan has the overall responsibility of assuring that services provided to the member are in alignment with the authorized services, and that the member is making expected progress. The health plan may decide to change CIS providers as needed if doing so would be in the best interest of the CIS member. Any time there is a change in the CIS provider for a given member, the health plan shall support the transition of care through warm hand-offs.

9. **Billing and Payment**

Health plans shall authorize CIS providers to render services and receive payment for three types of CIS services:

a. **Outreach Services**

Outreach services may be billed for services related to locating the member and conducting any additional screening services to determine program eligibility, and completing the consent process, including refusal to consent into the program. When the health plan or the CIS provider is unable to find the member, the health plan shall engage in assertive outreach services to locate and engage the member to accept CIS services. Completion of all activities tied to outreach will result in a single bundled payment. Completion of outreach activities should also reflect progress on the member's CIS status code. As outreach activities occur, member status code should transition from H2 (CIS – Contacted – Confirmed Eligible) to H4 (CIS – Contacted – Eligible Refused), H5

(CIS – Housing Pre-Tenancy), H6 (CIS – Housing Tenancy) or H8 (CIS – Unable to Contact), with movement to H5 the most likely route for a CIS member that has consented and is about to begin pre-tenancy services. Outreach services may only be billed to the health plan that the member is enrolled in at the completion of outreach activities. Since members who were previously in CIS but were unable to be contacted (i.e., status codes H7 and H8) may be disenrolled from the program and re-identified as potentially eligible for CIS (i.e., status code H1) through analytics, they would become eligible for Outreach Services once again.

b. Completion of the CIS Packet

The CIS Packet requirements are described in detail above. The provider completing the CIS Packet shall bill the health plan upon submittal of the CIS Packet documentation to the health plan. Payment shall be made by the health plan to the provider in the form of a single bundled payment. The bill must be sent to the health plan that the member is enrolled on the billing date, or to the CCS health plan if the member is a CCS member. This bundled payment shall only be made to CIS members who have transitioned to a status code of H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy) from a status code of H2 (CIS – Contacted – Confirmed Eligible). A bundled payment for subsequent re-assessments and plan update services will not be paid for by health plans. In instances where the CIS member previously in H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy) statuses transitioned to a status code of H7 (CIS – Beneficiary lost to follow up) and then was re-confirmed to be eligible for CIS, re-assessments and plan updates for CIS members in H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy) statuses shall be considered a part of the CIS monthly benefit.

c. CIS Monthly Benefit

CIS-specific housing supports provided shall encompass the list of CMS approved CIS benefits as previously described in Appendix A. However, as part of the CIS Health Action Plan Addendum, the health plan may also pay for all other non-housing services and supports that are available to qualifying members. Payment for any other housing or housing-related supports that fall outside of those listed in Appendix A is not allowed as a CIS/Medicaid benefit. See Appendix F for a list of homeless programs funded & CIS funded services.

Health plans should use a standard PMPM payment approach to pay for CIS pre-tenancy and tenancy services for CIS members in status H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy). Service providers must submit a monthly claim containing a CIS-specific supportive housing procedure code. This

claim should also contain all applicable encounter tracking codes for services rendered during a given month, along with dates each service was rendered.

In order to qualify for the full monthly payment, the member shall be in a H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy) status on the first day of the month. Health plans may pay a payment prorated on a daily basis for members in H5 or H6 status for part of the month. In instances where more than one service provider has rendered pre-tenancy or tenancy services in a single month, health plans are authorized to prorate the PMPM payment to more than one service provider proportional to the total hours of CIS work rendered.

In order to receive the CIS monthly payment, CIS providers are required to have documented at least 240 minutes of service (of which 75% must be face-to-face) on a monthly basis to receive the monthly capitation payment. The health plans may make exceptions to these requirements on a case-by-case basis, but MQD prefers face-to-face interaction for CIS members. Codes to capture minutes of services rendered to a member are provided in this memo. There should be a minimum of weekly visits for the first three (3) weeks when the member first enters pre-tenancy and after the member moves into housing to assist with immediate barriers and other high priority adjustment issues. Additionally, there must be documentation of the provision of at least one encounter tracking code for services rendered during the month. The specific encounter tracking codes for services rendered must align with the services the health plan has authorized for the member. In addition, health plans shall require reporting of housing status code changes from H5 (CIS – Housing – Pre-Tenancy) to H6 (CIS – Housing – Tenancy) (or vice versa) and/or H7 (CIS – Beneficiary Lost to Follow Up) by CIS providers.

The health plan shall collect more detailed data to track the CIS Provider's progress on completing or providing the member-specific services and support needs identified in the CIS Health Action Plan Addendums part of quarterly reassessments. This data shall be reportable to MQD as part of reporting requirements. Health plans will additionally submit a daily CIS member files to update MQD on CIS status code changes, as described further in memo QI-2003. Minimum requirements for a PMPM payment are preliminary and discussions around potential adjustments to this policy will occur between MQD, health plans and CIS provider agencies. Health Plans are encouraged to collaborate to develop streamlined billing guidelines (e.g., forms and formats for submission) and reporting requirements for homeless service providers.

d. Miscellaneous Payments

In addition to the standard PMPM approach, MQD recognizes that there may be instances where some Fee-For-Service (FFS) options for payment may be necessary; as one key example, a member who was previously in pre-tenancy who misses appointments may require multiple follow-up actions, and after several unsuccessful attempts may become lost to follow up (CIS status code H7 (CIS – Beneficiary lost to follow up). To encourage follow-up actions to locate and re-engage the member, MQD offers a FFS payment option at a proposed reimbursement rate that is relatively comparable to other activities in the program. The health plan is encouraged to use the FFS payment option judiciously to compensate for miscellaneous activities that occur outside of the bundled services as needed.

HCPCS codes along with appropriate modifiers and diagnostic codes used for billing and encounter data submission purposes, along with MQD’s proposed rates of reimbursement, are provided below. Health plans are required to submit all encounter data to MQD including encounters pertaining to services rendered under the capitation arrangement. MQD requires that encounter data be submitted regardless of whether the CIS services were rendered by health plan employees or service providers in the community, and even if in that month the plan does not have responsibility to pay the CIS providers. This is required to enable comprehensive tracking of services provided.

Service Category	Service Description	HCPCS Code	Modifier	Applicable Dx Codes	Proposed Rate
Billable Codes					
Outreach					
	Outreach and screening to verify program eligibility and obtain member CIS consent	T1023	N/A	Z13.9	\$85 one time bundled payment upon completion of eligibility verification and consent process.
Completion of the CIS Packet					
	Assessment	T2024	U1	Z02.89 ^a	\$150 bundled payment for the initial assessment/plan
	Individualized plan development	T2024	U2		
CIS Monthly Benefit					
	Supportive housing, per month	H0044	-	Z76.89	\$350 PMPM

Encounter-Tracking Codes					
<i>Pre-Tenancy & Tenancy Supports</i>					
	Provision of housing supports	H0043	U3		N/A
	Provision of medical reengagement and care coordination supports	H0043	U4		N/A
	Provision of QUEST and Other DOH Program referral supports	H0043	U5		N/A
	Provision of safety supports	H0043	U6		N/A
	Provision of supports to address Social Risk Factors	H0043	U7		N/A
	Provision of Financial assistance supports	H0043	U8		N/A
	Provision of employment and housing readiness supports	H0043	U9		N/A
	Provision of other supports not identified elsewhere	H0043	UA		N/A
	Re-assessment and plan revision	H0043	UB		N/A
	Other services to member	H0043	UC		N/A
	Case management, each 15 minutes <i>for CIS services</i>	T1016	U1		N/A
<i>Actions to Support Members Lost to Follow-Up and other Miscellaneous Activities</i>					
	Case management, each 15 minutes <i>for follow-up of crisis contacts and missed appointments</i>	T1016	U2		\$21.25 per 15 minutes of follow-up activities completed

⁹Additional codes to indicate applicable socioeconomic and psychosocial circumstances (Z55-Z65), including but not limited to homelessness, should also be provided on the claim.

Claims submitted by CIS provider shall include the appropriate Place of Service (POS) codes to indicate setting, and differentiate face to face and non-face to

face services. CIS services may be rendered via telehealth as appropriate, as long as the required face-to-face interaction requirements are met (See Section 16, Service Settings for more information). Services rendered via telehealth shall be billed with the additional and appropriate telehealth modifiers, and applicable POS codes, as outline in memorandum QI-1702A.

Outreach and other CIS services rendered by CIS providers on non-Medicaid members shall not be paid by Health plans but shall be paid by appropriate DHS/BESSD/Homeless Program Office (HPO) grant monies. The health plan shall pay for any services that may be authorized for eligible CIS members; in other words, if CIS can cover a service, then the health plan shall pay for that service. In these cases, the provider shall only bill health plans for approved CIS services rendered to Medicaid members, and shall continue to bill HPO for CIS services rendered to non-Medicaid members as well as non-CIS housing-related services rendered to Medicaid members. See Appendix F for a list of HPO funded & CIS funded services.

10. Contracting Requirements

Health plans shall enter into a provider contract with each of the CIS providers that will be billing for services described in the Billing and Payments section.

- Health plans shall maintain or contract with a sufficient number of dedicated staff or contractors willing to gain knowledge, expertise and experience to implement supportive housing services for Medicaid members.
- Health plans are strongly encouraged to participate in the Homeless Management Information System (HMIS).

MQD strongly encourages the health plan to establish team-based care supports to address CIS. The use of peer support specialists and community health workers as part of the team is encouraged and allowed. When utilized, the monthly benefit payments shall include services provided by all team members. The health plans shall lead the planning and provision of collaborative and joint provider orientation and training sessions; MQD can support health plans as needed. These orientation and training sessions shall address the standardization of CIS billing requirements, CIS payment methodologies, CIS provider qualification standards, and Medicaid program integrity concerns around CIS.

11. MQD Learning Communities and Rapid Cycle Assessments

Health plans shall participate in quarterly “learning communities” with providers and the State to ensure that health plans and providers are sharing and adopting best practices throughout the duration of the CIS program. The frequency of these “learning communities” may be monthly or more frequently when necessary, such as during the initial rollout of CIS services. Health plans shall also participate in MQD-led quarterly rapid

cycle assessments of the health plans' progress towards implementation and achievement of the desired goals and outcomes of CIS. Forums identified herein shall be used to address ongoing health plan challenges, and advance the CIS program towards quality measurement and Value-Based Purchasing (VBP).

12. Qualifications of CIS Providers

Contracted CIS providers must have at least one year of demonstrated experience and ability to provide services per the specifications of the contract. This includes maintaining all necessary licenses, registrations and certifications as required by law. Health plans may develop more stringent or additional credentialing requirements beyond the minimum requirements stated here.

Direct service providers must possess the appropriate qualifications. Preferred qualifications are provided below:

Category	Direct Service Provider Preferred Qualifications
Education	Bachelor's degree in a human/social services field
Experience	1-year case management experience, or 1-year field experience with a homeless or transitional housing agency. Field experience may include community outreach; locating individuals on the street; completing assessments on homeless individuals; finding short- and long-term housing; and/or assisting individuals to apply for documents, benefits and housing.
Skills	Knowledge of principles, methods, and procedures of services included under Community Integration Services, or comparable services meant to support individuals to obtain and maintain residence in independent community settings.
Supervision	Staff supervision that helps to develop low barrier, assertive engagement skills, build member motivation, conduct thorough assessments, establish meaningful housing plans, ensure member and staff safety, and support self-care; a case review process to help staff problem-solve around particular management challenges and to inform assessments, housing plans, and discharges is also recommended.

At orientation newly hired direct service providers are required to complete training in Supportive Housing Best Practices in outreach, engagement, and providing supportive services; common DSM V diagnoses in the CIS population and addressing them in Fair Housing; Harm Reduction principles; Housing Referrals and Coordinated Entry processes; HIPAA; and Medicaid documentation and false claiming. Additionally, providers must complete annual training in Trauma Informed Care, HIPAA, Fair Housing, and on how to report and address Major Unusual Incidents/Adverse Events.

13. Program Integrity Responsibility

Health Plans must ensure services paid for and covered under CIS were rendered and properly billed and documented by CIS providers. Health plans shall follow existing program integrity responsibilities in the health plan contract regarding the following:

- Encounter Data Analysis
- Visit Verification Procedures
- Recoupment of Overpayments
- Suspension, Withhold, Sanctions and Termination Activities
- Auditing Compliance

14. Documentation

All contacts and activities that assist a CIS member shall be documented by the CIS provider. The CIS Provider and/or the health plan shall document all outreach attempts to engage member. The health plan shall work in collaboration with CIS providers to track the provision of services.

Progress notes should follow principles of documentation generally accepted in the social work field, including, but not limited to the following elements:

- Date, time, type of visit, method of contact (face to face or phone) and place of contact;
- A summary of issues addressed (e.g., independent living skills, family, income/ support, food assistance, legal, medication, educational, housing, interpersonal, medical/dental, vocational, engagement in clinical and/or community resources and services);
- Member's response and status/ progress in view of housing support plan;
- CIS provider's observations and impressions;
- Collaboration with social services and community-based organizations or natural supports, beyond the CIS and/or Health Plan staff.
- Any referrals or other follow up to implement or adjust housing support plan; and
- Signature or electronic signature using credentials, as applicable.

Progress notes should follow principles of documentation generally accepted in the social work field.

15. CIS Member Rights and HCBS Rule

When the member becomes a CIS supportive housing tenant, the member's CIS- supportive housing services must be provided in a community-integrated setting selected by the member as defined in the Home and Community-Based Setting (HCBS) rules in 42 C.F.R. Sec. 441.530. Details of the HCBS Member Rights can be found in Appendix G. The CIS services provider and health plan must review any modifications to the member's rights with

member as described in Appendix G at least quarterly to determine if it is still effective and needed.

16. Service Settings

CIS services shall be rendered to the member in a setting appropriate to the type of service being rendered. Pre-tenancy housing transition services may be rendered on the street, on the beach, in a vehicle, in a shelter, in a residential institutional or licensed setting, in an emergency room, in an acute institution, in a health care provider office, or other locations of the member's choosing. Tenancy services are most often rendered at the member's home but may also be rendered in other community setting where pre-tenancy services are rendered. Services may also be rendered via an approved telehealth modality, if determined by the health plan to be appropriate and effective and agreed to by the member.

17. Disenrollment and Re-Enrollment

Members may be disenrolled from the CIS program. a member disenrolls from CIS, the member's current status code must be end dated and sent to MQD by the health plan. Reason codes may be added at a later date.

Possible Disenrollment Reasons

The member:

- Requested voluntary disenrollment - option to "opt out" of the CIS program;*
- Moved into a licensed/certified HCBS home, therefore no longer meets criterion for CIS services;
- Lost Medicaid eligibility;
- Is lost to follow-up (i.e., with a status code of H7 or H8);
- Has been stably housed for at least 12 months without incident, and the member and health plan mutually agree that CIS services are no longer needed.

To report a CIS eligible member in CIS status code of either H5 or H6 as being lost to follow up (CIS status code H7), MQD is requiring that at least three unsuccessful attempts to reach the member in the last three months be made by a health plan or their designee. To report a potentially eligible member as being unable to contact (CIS status code H8), MQD is requiring that at least three unsuccessful outreach attempts in the last six months be made by a health plan or their designee to engage the member. These unsuccessful attempts to reach the member are to be documented in the member record. In these instances, the health plan shall submit a status code of H7 (CIS – Beneficiary Lost to Follow Up) or H8 (CIS – Unable to Contact) along with a termination date. Upon disenrollment, members will no longer have an active CIS status code. Members who are disenrolled from CIS may be re-considered for identification and eligibility at a later date. If re-entering CIS, eligibility must be re-confirmed, and member consent must be re-obtained.

Notice of Adverse Benefit Determination

Notice of Adverse (NOA) Benefit Determination shall be issued to a member when member is disenrolled from CIS (moves to Status code H7 (CIS – Beneficiary Lost to Follow Up) or H8 (CIS – Unable to Contact) or if the health plan concludes that the member does not meet initial eligibility criteria for CIS (Status code H3 (CIS – Contacted – Not Eligible)). NOAs for Status codes H7 or H8 shall indicate that the CIS disenrollment effective date will be the first of the following month. NOAs for Status code H3 (CIS – Contacted – Not Eligible) must provide information on the right to appeal the determination of ineligibility. If a reassessment is requested, the same CIS assessment tools previously used to evaluate the member in the initial assessment shall be used to conduct the CIS eligibility reassessment. The process for such an appeal must comply with the requirements in 42 C.F.R. Subpart F for an adverse benefit determination. The health plan shall incorporate a protocol for how CIS appeals by providers and members shall be reviewed and addressed into its overall member and provider grievance and appeals processes. The NOA shall be mailed to the member and the CIS provider by the health plan, or hand-delivered to the member when possible.

Opt-Out*

Members enrolled in CIS will have the option to opt-out of the CIS program at any time. This opt-out option shall only be initiated by the member. Member may inform the CIS provider or the health plan when exercising the opt-out option. Members who opt out and are disenrolled from the CIS program shall have the option to re-enroll after the member is reassessed and is determined to be eligible for the CIS program. The health plan shall continue to assist members who opt out of the CIS program with existing non-CIS wrap around services, including moving to an HCBS home as appropriate.

Re-Enrollment

Nothing shall prevent a currently enrolled Medicaid member who was formerly enrolled in the CIS program from again enrolling again in the CIS program if the CIS Consent and Member Requirements form is signed by member and member meets eligibility criteria.

18. Special considerations for CCS Members

CCS shall be responsible for the CIS service delivery when member is enrolled in CCS. Since member identification and referral for CIS may occur from multiple external sources, and to encourage a ‘no wrong door’ policy for external referrals, such referrals shall be processed through completion of the Outreach Services step in Section 9.a, and member progress made up to confirmation of eligibility by the QI health plan that receives the external referral; in other words, the member shall be transitioned from a status code of H1 to a status code of H2 (CIS – Contacted – Confirmed Eligible), H3 (CIS – Contacted – Not Eligible), or H4 (CIS – Contacted – Eligible Refused). This would include responding to the referring entity, and for following up if there is incomplete information. The QI health plan shall be

responsible for completing outreach services before transitioning the member to the CCS plan. It is expected that the CCS plan will complete the consent and member assessment process to transition the member into a subsequent status code (e.g., H5 or H6). If the QI health plan is unable to reach a potentially eligible member [i.e., status code H8 (CIS – Unable to Contact)], the QI health plan shall disenroll the member, but additionally transition the information available on the member to the CCS plan so that the CCS plan is well-poised to re-attempt to contact the member in the future. If a member is already in CIS when they are newly enrolled in CCS, the QI health plan shall forward all information on these members to the CCS health plan and the CCS plan should assume CIS services beginning with the status code that the member is in. All subsequent CIS requirements from Section 4 forward in the memorandum forward shall be the responsibility of the CCS health plan. All transitions of CIS members from the QI health plan to the CCS health plan shall include ‘warm hand-offs.’

Health plans shall follow existing transition of care protocols in their contract when a CIS member moves into or out of CCS, or moves from one QI health plan to another. CIS status code appears on the 834 daily file on the 2700 loop, elements N1 through DTP03. When members are enrolled in QI and CCS, the most current CIS information will be available to both plans to facilitate transitions. The CIS status code shall only be updated when the member transitions to a new CIS status code under the CCS plan’s care. Please refer to additional guidance in memo QI-2003 (2019) on status code submission.

19. Special considerations for Referrals from Hospitals

For hospital-based referrals, the timeframe for the health plan to confirm eligibility criteria, conduct an outreach visit, and to obtain consent is necessarily compressed. As such, the health plans need to visit the facility before the member leaves or arrange for an entity onsite to meet the member.

Health plans shall work closely with hospital staff on proactive identification of members potentially eligible for CIS as well as early notification of an admission for members potentially eligible for CIS, and are encouraged to utilize existing electronic notification protocols to assist with the referral process. Health plan staff or their designee shall screen the member to assess eligibility, obtain consent, organize appropriate follow up with the member, and engage a CIS provider as appropriate. The health plan staff or CIS provider will set up a time to visit the member to do the assessment. Upon determining the member is eligible for CIS, obtaining consent for CIS, and completing a member assessment, the health plan shall submit a status code of H5 (CIS – Housing – Pre-Tenancy) to MQD.

Successful enrollment into status H5 (CIS – Housing – Pre-Tenancy) when member is assessed in the hospital may bypass the status code H2 (CIS – Contacted - Confirmed Eligible); in some cases, when referral, eligibility confirmation and consent are completed

on the same day, the status code of H1 (CIS – Potentially Eligible) may also be bypassed. In these cases, the health plan would not need to submit “by-passed” status codes to MQD. If the transition from one status code to another does not occur on the same day, then both status codes must be reported. Follow up includes immediate coordination of health care benefits by the Health Plan.

20. Special considerations for the Queen’s Care Coalition (QCC)

The Queen’s Care Coalition (QCC) provides coordinated care for Super Utilizer and Native Hawaiian patients at risk for readmission by connecting them to community resources such as appropriate medical care, supportive temporary or permanent housing services, social services, behavioral health, etc. with the goal to navigate patients into progressively better circumstances while reducing unnecessary hospital utilization. The pre-tenancy services provided by QCC include navigation, which includes an assessment of a member’s medical condition, registration into various systems, such as but not limited to the HMIS system, completion of VI-SPDAT evaluations, and gathering of all necessary documentation required for accessing housing.

Navigation is patient-centered, and may include, but is not limited to the following:

- a. Coordination of follow-up appointments
- b. Connecting primary care and specialty care services
- c. Education on medications
- d. 30-day transitional care
- e. Access to transportation
- f. Accessing proper documentation
- g. Access to benefits
- h. Insurance access
- i. Linkage to community resources including immediate shelter and then permanent housing

As such, QCC operates as a provider of pre-tenancy services and shall be considered and treated a CIS provider by the health plan. QCC shall send a referral form to the member’s Health Plan for the Health Plan to screen for CIS eligibility, moving member to status code H1 (CIS – Potentially Eligible). After the Health Plan confirms eligibility, QCC may add the member’s signed CIS consent to their current housing assessment *or* use the CIS consent form that includes the consent for CIS services, moving member to status code H2 (CIS – Contacted – Confirmed Eligible). The health plan may then authorize QCC to conduct the CIS assessment. Copies of the completed CIS Packet shall be sent to the Health Plan. Once received, the Health Plan shall review the CIS Packet and then move to authorize CIS Pre-Tenancy services as appropriate. The CIS pre-tenancy services provided by QCC may be billed to the member’s health plan and shall be paid as Outreach Services (Section 9.a) and Completion of CIS Packet (Section 9.b). There is an expectation that QCC will coordinate a

warm hand-off to a CIS provider to provide additional pre-tenancy and tenancy support services as needed to the member, and health plans shall assist in coordinating this warm hand-off. MQD encourages other hospitals and clinics to provide the same services as QCC. Assessment and plan development services must follow the rules of conflict free case management. QCC shall be subject to the same reporting and documentation requirements as other CIS providers.

These services are furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. The CIS program is voluntary for members.

- a. Pre-tenancy supports:
 - i. Conducting a needs assessment identifying the member's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); providing assistance in budgeting for housing and living expenses; assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.
 - ii. Assisting members with connecting to social services and the Coordinated Entry System homeless and housing service providers, to help with finding and applying for independent housing necessary to support the member to meet their medical care needs.
 - iii. Identifying and establishing short and long-term measurable goal(s) and establishing how goals will be achieved and how concerns will be addressed. (Examples of short term goals could include: identifying housing needs and preferences; assistance with move in arrangements, support from service coordinator to ensure the housing unit is safe, meets the member's needs and ready for move in; support from service coordinator in acquiring necessary documentation for housing application and move in; assisting with housing search and completing housing applications; assistance from service coordinator during any housing interviews with landlords or property managers for emotional or behavioral support; requests for reasonable accommodations or appeals after housing application denials).
 - iv. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
 - v. Providing supports and interventions per the person-centered plan.
- b. Tenancy sustaining services:
 - i. Providing service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed. This should include the development of a crisis plan or Eviction Prevention Plan, created with the member, that includes the early identification of behaviors that could jeopardize tenancy (for

- example: noise violations, late rent payments, violent or threatening behaviors, guests overstaying guest policy).
- ii. Coordinating and linking the member to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
 - iii. Providing entitlement assistance including assisting members to obtain documentation, navigating and monitoring housing application process, and coordinating with the entitlement agencies and Coordinated Entry providers for rental subsidies and any subsequent reauthorizations for rental subsidies.
 - iv. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
 - v. Providing supports to assist the member in the development of independent living skills, such as skills coaching and modeling, financial counseling, and anger management or behavioral supports.
 - vi. Providing supports to assist the member in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. This may include support creating an Eviction Prevention Plan with the tenant, advocating for a rent repayment plan or in the event that eviction proceedings begin, seeking a mutual rescission agreement with the landlord to prevent an eviction on the member's record.
 - vii. Coordinating with the member to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
 - viii. Connecting the member to training and resources that will assist the member in being a good tenant and lease compliance, including ongoing support with activities related to household management.

Part I: Referral Source

Who is Referring this member to CIS?	<input type="checkbox"/> Self <input type="checkbox"/> Family/Friend <input type="checkbox"/> Medical Care Provider <input type="checkbox"/> Nursing Home Provider <input type="checkbox"/> Social Services Provider <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other, please specify		Other Referral Source:
Referrer Name:	Agency Name (if applicable):		Contact Person for Additional Information:
Referral Date:	Contact Phone Number:	Contact Fax Number:	Contact E-Mail Address:

Part II: Member Information

Member First Name	Member Last Name	Middle Initial	Medicaid ID#	Member Age (Years)	
Current Residential Address:					
Street:	City and State:		Zip Code:		
Mailing Address (if different from current address):					
Street:	City and State:		Zip Code:		
Best Contact Phone Information:	Number	Can receive texts?	Email Address:	Any friends or family who can help reach you? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify:	Contact Name:
	1.	Yes <input type="checkbox"/> No <input type="checkbox"/>			Contact Ph Number:
	2.	Yes <input type="checkbox"/> No <input type="checkbox"/>			Relationship to Member:
If deemed eligible for CIS, anyone the member would like present for	Yes <input type="checkbox"/>	Name:	Name:		
	No <input type="checkbox"/>		Ph Number:	Ph Number:	
	If yes, list:		Relationship to Member:	Relationship to Member:	

the assessment and action planning steps?			
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Part III: PRESUMPTIVE Member Eligibility Information (Subject to Verification and Confirmation)

Please indicate how you believe the member is eligible to receive CIS services.

PART A: HEALTH NEEDS-BASED CRITERIA

Select	Criteria (At Least One MUST Apply for Member to be Eligible)	Qualifying Diagnoses
<input type="checkbox"/>	Individual assessed to have a behavioral health need which is defined as one or both of the following criteria:	
<input type="checkbox"/>	Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; <u>and/or</u>	
<input type="checkbox"/>	Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1 indicating the need for outpatient day treatment for Substance Use Disorder (SUD) treatment.	
<input type="checkbox"/>	Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).	

PART B: HOUSING CRITERIA

Select	Criteria (At Least One MUST Apply for Member to be Eligible)	Notes
<input type="checkbox"/>	Homeless: , defined as lacking a fixed, regular, and adequate nighttime residence (MEMBER WILL QUALIFY IF THEY MEET EITHER CRITERIA BELOW)	
<input type="checkbox"/>	Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; <u>or</u>	
<input type="checkbox"/>	Living in a supervised shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels).	
<input type="checkbox"/>	At risk of homelessness defined as an individual who will lose primary nighttime residence. (MEMBER WILL QUALIFY IF THEY MEET ALL CRITERIA BELOW)	

<input type="checkbox"/>	There is notification in writing that their residence will be lost within 21 days of the date of application for assistance; and	
<input type="checkbox"/>	No subsequent residence has been identified; and	
<input type="checkbox"/>	The individual does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter;	
<input type="checkbox"/>	At risk of homelessness defined as an individual who will lose primary nighttime residence. (MEMBER WILL QUALIFY THROUGH EITHER DEFINITION OF INSTITUTIONAL STAYS AND IF THE MEMBER IS IMMEDIATELY TRANSITIONING OUT OF THE SETTING)	
<input type="checkbox"/>	History of frequent institutional stays (two or more instances in the past 12 months); or	
<input type="checkbox"/>	History of lengthy institutional stays (One or more stays lasting 60 days or more); and	
<input type="checkbox"/>	Member is transitioning out of an institutional setting without a community residence.	
	<i>Select the type of institutional setting the client is currently in (if applicable)</i> <input type="checkbox"/> Nursing Facility/Other LTC <input type="checkbox"/> Inpatient psychiatric hospital <input type="checkbox"/> Inpatient medical hospital <input type="checkbox"/> Correctional program/institution	
Referring Party Observations/Concerns (Use the space below to note any specific health concerns or factors the Health Plan should consider in reviewing and prioritizing this referral):		

Part IV: Additional Pertinent Information

Is the member currently a threat to self or others?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, Explain:
Is the member in any immediate danger or did the member disclose experiencing violence or abuse by or fear	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, Explain:

of another party with whom they are in contact?		
Does the member have interpretation needs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, in which language(s) does the member need interpretation services?
Other Pertinent Information:		

I hereby certify that the above statements are true and correct to the best of my knowledge.

Referring Party Name	Date	Signature
Preferred Contact	<input type="checkbox"/> Phone Number:	<input type="checkbox"/> Email Address:

Risk Factor Evidence Requirements

Evidence to substantiate how the member meets criteria for CIS must be documented as part of the referral process. Community providers making referrals shall attach any available evidence that corresponds to the eligibility criteria selected in the referral form. The absence of complete documentation should not preclude referral to CIS.

1. Attach any documentation available to substantiate or further describe the member’s qualifying health condition(s)
 - a. If the member has a Mental Health Need,
 - i. Provide any certification of the presence of a Severe and Persistent Mental Illness;
 - ii. Provide any other clinical documentation or attestation from a provider of the presence of a Severe Mental Illness;
 - iii. If the member is enrolled in CCS, documentation does not need to be provided.
 - b. If the member has a Substance Use Need,

- i. Provide clinical documentation or attestation that the substance use disorder meets ASAM level 2.1 or higher;
 - ii. Provider verification through ADAD's system, if available.
 - c. If the member has a complex Physical Health Need,
 - i. Provide clinical documentation or attestation from a provider of the presence of a complex physical health need;
 - ii. Provide any other available evidence of routine or excessive use of emergency and inpatient settings;
 - iii. If the member is already eligible for LTSS services, documentation does not need to be provided.
2. Attach all documentation available to substantiate a history of homelessness or at risk of homelessness, including but not limited to the following
 - a. If the member is already homeless, include as available:
 - i. An HMIS record or record from a comparable database;
 - ii. A written observation by an outreach worker of the conditions where the individual was living;
 - iii. A certification of homelessness;
 - iv. A written referral by another housing or service provider;
 - v. Where evidence described above cannot be obtained, a certification by the individual seeking assistance, which must be accompanied by the intake worker's documentation of the living situation of the individual seeking assistance and the steps taken to obtain evidence above.¹
 - NOTE:** Third-party letters must be on agency letterhead, signed and dated. The name and title of the person signing should be indicated.
 - b. If the member is at risk of homelessness, based on the criteria selected, the following evidence may be provided:
 - i. Eviction letter and proof of current residency at the mailing address from where the member is being evicted
 - ii. Evidence individual has a history of frequent or lengthy residence in a facility (Facility Face sheet or Discharge Summary that includes admit, discharge and transfer dates as applicable), and documentation that the individual will be discharged soon.

Part I: Member Identification and Demographics

Member First Name		Member Last Name		M.I.	Preferred Name		Medicaid ID#	Date of Birth:
Current Residential Address:								
Street:					City and State:			Zip Code:
Mailing Address (if different from current address):								
Street:					City and State:			Zip Code:
Best Contact Phone Information:	Number	Can receive texts?		Email Address:	Any friends or family who can help reach you? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify:	Contact Name:		
	1.	Yes <input type="checkbox"/> No <input type="checkbox"/>				Contact Ph Number:		
	2.	Yes <input type="checkbox"/> No <input type="checkbox"/>				Relationship to Member:		
If deemed eligible for CIS, anyone the member would like present for the assessment and action planning steps?		Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list:		Name:		Name:		
				Ph Number:		Ph Number:		
				Relationship to Member:		Relationship to Member:		
Member QUEST Health Plan: <input type="checkbox"/> AlohaCare <input type="checkbox"/> HMSA <input type="checkbox"/> Kaiser <input type="checkbox"/> Ohana <input type="checkbox"/> UHC				Is Member in CCS? <input type="checkbox"/> Yes <input type="checkbox"/> No	Lead Health Plan's Member ID:		Member QUEST ID:	
Member HMIS ID:		<input type="checkbox"/> Unknown <input type="checkbox"/> Member not in HMIS		Is the Member a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, VA ID: <input type="checkbox"/> Unknown		Other Insurance/ID #:	
Would the member prefer to receive services from one or more of homeless service providers? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, identify:								
Is the member currently received any services related to their homelessness? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please Respond:								

#	Agency(ies) Providing Services:	Types of Services Being Provided:	
1.			
2.			
Other:			
These questions may be directed to the member:			
Do you think of yourself as: <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Queer, pansexual, and/or questioning <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else, please specify: <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer		Do you think of yourself as: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender man/trans man/female-to-male (FTM) <input type="checkbox"/> Transgender woman/trans woman/male-to-female (MTF) <input type="checkbox"/> Genderqueer/gender nonconforming neither exclusively male nor female <input type="checkbox"/> Additional gender category (or other); please specify: <input type="checkbox"/> Decline to answer	
		Preferred Pronoun:	

Part II: Additional Pertinent Information

Is the member currently a threat to self or others?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, Explain:
Is the member in any immediate danger or did the member disclose experiencing violence or abuse by or fear of another party with whom they are in contact?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, Explain:
Does the member have interpretation needs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, in which language(s) does the member need interpretation services?

Other Pertinent Information:

Part II. Member Eligibility Confirmation and Consent

The member is confirmed to qualify for CIS based on the following criteria:

PART A: HEALTH NEEDS-BASED CRITERIA		
Select		Criteria (At Least One MUST Apply for Member to be Eligible)
<input type="checkbox"/>		BEHAVIORAL HEALTH NEED, BASED ON:
	<input type="checkbox"/>	MENTAL HEALTH NEED <u>and/or</u>
	<input type="checkbox"/>	SUBSTANCE USE NEED
<input type="checkbox"/>		COMPLEX PHYSICAL HEALTH NEED
PART B: HOUSING CRITERIA		
Select		Criteria (At Least One MUST Apply for Member to be Eligible)
<input type="checkbox"/>		HOMELESSNESS
	<input type="checkbox"/>	UNSHELTERED
	<input type="checkbox"/>	SHELTERED
<input type="checkbox"/>		AT RISK OF HOMELESSNESS
	<input type="checkbox"/>	RISK OF IMMEDIATE EVICTION
	<input type="checkbox"/>	FREQUENT INSTITUTIONAL STAYS
	<input type="checkbox"/>	<i>Transitioning out of:</i> <input type="checkbox"/> Nursing Facility/Other LTC <input type="checkbox"/> Inpatient psychiatric hospital <input type="checkbox"/> Inpatient medical hospital <input type="checkbox"/> Correctional program/institution

I, _____ voluntarily agree to enroll in Community Integration Services (CIS).		
Member Signature	Member Advocate Signature (if applicable)	Date
I hereby certify that the information contained in this form is true and correct to the best of my knowledge.		
Interviewer Signature	Interviewer Name & Title	Date
CIS Services Agency or Health Plan Name (as applicable)	Phone Number & E-mail Address	

Part I: Agency Information

CIS Agency:			CIS Provider ID:		Interviewer Name & ID (If applicable):
Type of Assessment:	Initial Assessment	Re-Assessment	Assessment Date Initiated:	Assessment Date Completed:	Notes About Assessment/Re-Assessment (if any):
	<input type="checkbox"/>	<input type="checkbox"/>			

Part II: Member Information

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

If deemed eligible for CIS, anyone the member would like present for the assessment and action planning steps?	Yes <input type="checkbox"/>	Name:	Name:
	No <input type="checkbox"/>	Ph Number:	Ph Number:
	If yes, list:	Relationship to Member:	Relationship to Member:

**Information available to the Health Plan*

SECTION A: MEMBER SELF-ASSESSMENT

Part III: Health and Wellness Assessment

I am going to ask you some questions about your health, well-being, and housing history. We are interested in hearing from you. This information will help us find out which services are best for you. Many of the questions are very personal. If you do not want to answer a question, you don't have to.

These questions ask about your health over <u>the past 30 days</u> .						Scoring	
1. Would you say that in general your health is:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Fair or Poor	<input type="checkbox"/>
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during <u>the past 30 days</u> was your physical health not good?	Number of Days _____				>14 days	<input type="checkbox"/>	
3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during <u>the past 30 days</u> was your mental health not good?	Number of Days _____				>14 days	<input type="checkbox"/>	
4. During <u>the past 30 days</u> , for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	Number of Days _____				>14 days	<input type="checkbox"/>	
5. Do you have any disabilities and/or chronic medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Specify if named: _____			Yes	<input type="checkbox"/>
6. Do you have any mental health conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Specify if named: _____			Yes	<input type="checkbox"/>

7. Do you have any substance use disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Specify if named: _____				Yes	<input type="checkbox"/>
Please choose the response that best corresponds to how often <u>in the last 6 months</u> you have experienced the following:		Never	Almost Never	Sometimes	Fairly Often	Very often		
8. In the past 6 months, how often have you been physically hurt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sometimes or more	<input type="checkbox"/>	
9. In the past 6 months, how often have your children or someone close to you been physically hurt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sometimes or more	<input type="checkbox"/>	
10. In the past 6 months, how often has someone verbally hurt you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sometimes or more	<input type="checkbox"/>	
11. In the past 6 months, how often have you been emotional hurt or been controlled by someone living with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sometimes or more	<input type="checkbox"/>	
12. In the past 6 months, how often have you felt unsafe where you are currently living?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sometimes or more	<input type="checkbox"/>	
13. Have you been approached by the police in the past 3 months for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ # Times						Yes	<input type="checkbox"/>	
14. Have you been arrested, or have you spent a day in jail in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ # of days						Yes	<input type="checkbox"/>	
15. Have you gone to an emergency room in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ # of times						Yes	<input type="checkbox"/>	
16. Have you been admitted or stayed overnight at a hospital for a medical reason in the past 3 months?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ # of days	Yes	<input type="checkbox"/>	
17. Have you been admitted or stayed overnight at a hospital for a behavioral health reason (e.g. mental health, substance use) in the past 3 months?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ # of days	Yes	<input type="checkbox"/>	
18. Have you stayed at a crisis home or unit in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ # of days						Yes	<input type="checkbox"/>	

We are interested in finding out about your drug and alcohol history. Your responses will <u>not</u> impact your eligibility for services.							
In the last 30 days:							
19. How often have you drank alcohol?	Never	Once every couple of weeks	Once a week	A couple times a week	Every day		
20. How often have you used illegal drugs?	Never	Once every couple of weeks	Once a week	A couple times a week	Every day		
20(a). If using illegal drugs, please list drugs used in the last 30 days:	Methamphetamine <input type="checkbox"/>	Opioids/Heroin <input type="checkbox"/>	Marijuana/Hashish <input type="checkbox"/>	Synthetic marijuana/K2 <input type="checkbox"/>	Cocaine <input type="checkbox"/>	Other <input type="checkbox"/>	
I want to ask you a few questions about your recent healthcare. Please answer to the best of your recollection:							
About how long has it been since...							
	Within the past month	Within the past 3 months	Within the past year	Within the past 2 years	Within the past 5 years	5 or more years ago/ I don't know	n/a
21. You last visited a doctor for a routine checkup?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. You last visited your psychiatrist, psychologist or other mental health doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The next set of questions are about any medications you have been prescribed by a doctor or other health professional.							
Question	Yes	No	n/a	Question	Yes	No	n/a
23. Do you ever forget to take your medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Are you careless at times about taking your medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. When you feel better, do you sometimes stop taking your medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Sometimes if you feel worse when you take the medicine, do you stop taking it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. Is it difficult for you to pick up prescribed medications from the pharmacy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Is it difficult for you to take the medications you have been prescribed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Part IV: Housing Status Assessment

29. In the last 30 days, how many days have you lived: (Enter number of days)	Outside (including street, car, camper/RV or park) _____ days	at an emergency shelter _____ days	at a temp/transitional shelter _____ days	in a supervised group home _____ days	in a shared apartment _____ days	in an independent apartment _____ days	Outside >14 days	<input type="checkbox"/>	
30. In the last 3 years, how many times have you experienced homelessness?	_____ Times						>1 Time	<input type="checkbox"/>	
31. How long have you experienced homelessness this last time?	_____ Years		_____ Months					≥1 year	<input type="checkbox"/>
32. Have you been a victim of human or sex trafficking? This includes forced work, forced prostitution, or sexual acts to pay a debt.							Yes	<input type="checkbox"/>	
a. Are you a victim of human or sex trafficking now?							Yes	<input type="checkbox"/>	
33. Some people may be so sad, angry or hurt, that they have serious thoughts of hurting themselves or others. Sometimes people feel so depressed about the future that they may consider attempting suicide, that is, taking some action to end their own life.							FLAG	<input type="checkbox"/>	
a. Are you having any thoughts of harming other people?				<input type="checkbox"/> Yes <input type="checkbox"/> No					
b. Do you have a plan to harm yourself or take your own life?				<input type="checkbox"/> Yes <input type="checkbox"/> No					
34. What were the primary reasons that caused you to experience homelessness (last occurrence if multiple) or have placed you at risk of homelessness?									

a. <i>Mental Health or Substance Use Disorder</i>		b. <i>Physical Health Condition or Disability</i>		c. <i>Stress and Violence</i>		d. <i>Economic Reasons</i>		
<input type="checkbox"/>	Alcohol or drug use	<input type="checkbox"/>	Illness or medical problem	<input type="checkbox"/>	Divorce/separation	<input type="checkbox"/>	Loss of public housing or section 8 voucher	
<input type="checkbox"/>	Left a substance abuse treatment program and had nowhere to go	<input type="checkbox"/>	Released from a hospital with nowhere to go	<input type="checkbox"/>	Death in the family or death of a loved one	<input type="checkbox"/>	Loss due to foreclosure including eviction from a foreclosed rental property	
<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	Disabled	<input type="checkbox"/>	Family or domestic violence	<input type="checkbox"/>	Evicted from a foreclosed rental property	
<input type="checkbox"/>	Other reasons exacerbated by mental health disorders or substance abuse	<input type="checkbox"/>	Other reasons exacerbated by physical health conditions or disabilities	<input type="checkbox"/>	Argument with family or friends	<input type="checkbox"/>	Released from jail or prison and had nowhere to go	
				<input type="checkbox"/>	Loss of housing due to non-economic reasons (house fire, lease violation, etc.)	<input type="checkbox"/>	Unable to pay rent	
						<input type="checkbox"/>	Unable to pay mortgage	
						<input type="checkbox"/>	Lost job	
				<input type="checkbox"/>	Relocation or transition from another state	<input type="checkbox"/>	SSI or SSD cut off or benefits canceled	
Other reasons:								
Are your reasons for currently experiencing homelessness or being at risk for homelessness related to the COVID-19 Public Health Emergency?							<input type="checkbox"/> Yes	<input type="checkbox"/> No

Part V: Housing Navigation and Placement

<p>Complete Questions 1-8 and add any notes if the member is in pre-tenancy. If member is in tenancy, complete Question 9 & 10.</p>						
1. If you could choose, where would you like to live:	Outside (including street, car, camper/RV or park) <input type="checkbox"/>	Emergency shelter <input type="checkbox"/>	Temp or transitional shelter <input type="checkbox"/>	Supervised group home <input type="checkbox"/>	Shared apartment or home <input type="checkbox"/>	Single occupancy apartment <input type="checkbox"/>
2. Would you be interested in housing made available to people living with HIV/AIDS?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Does your household have any pets?	<input type="checkbox"/> Yes		<input type="checkbox"/> No		Type and # of pets: _____	
4. How many household members do you live with?	Adults:		Children:		List ages for any children (in years):	
5. Regarding smoking, are you interested in housing that....	<input type="checkbox"/> Allows smoking indoors		<input type="checkbox"/> Allows smoking indoors or on the grounds		<input type="checkbox"/> Any smoking policy	<input type="checkbox"/> I prefer a smoke-free residence
6. Some housing options do not prevent residents from using drugs or alcohol while others do, would you prefer:		<input type="checkbox"/> No policies against alcohol or drug use		<input type="checkbox"/> Dry Housing (no drinking or drug use)		<input type="checkbox"/> Dry housing intended for former substance users
7. When will you be in need of housing?	<input type="checkbox"/> Immediately		<input type="checkbox"/> Within 1 month	<input type="checkbox"/> Within 3 months	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6 months or more
8. What are your accessibility needs:						
<input type="checkbox"/> Access to apartment without stairs <input type="checkbox"/> Grab bars in bathroom <input type="checkbox"/> Live in caregiver Other (Specify):		<input type="checkbox"/> Doorways at least 32 to 36 inches wide <input type="checkbox"/> Lever door handles <input type="checkbox"/> Specialized equipment		<input type="checkbox"/> Roll in shower <input type="checkbox"/> Front knob on appliances <input type="checkbox"/> Electrical upgrade <input type="checkbox"/> No physical accessibility needs		

<p>Complete Questions 1-8 and add any notes if the member is in pre-tenancy. If member is in tenancy, complete Question 9 & 10.</p>		
9. Are you satisfied with your current housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, what are your concerns?
10. Do you have any new accessibility needs since you were housed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Notes:		

Part VI: Non-Monetary Resources and Supports

1. Does your household have a car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please describe the member's transportation resources:	
2. Do you have a Handi-Van, Para-Transit Services or Buss Pass?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3. Do you have other transportation options?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
4. Do you have a Legal Guardian/Power of Attorney/Rep Payee to assist in decision making?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, Person's Name:	Contact Information (Phone):
5. Do you have someone who you can count on in times of need?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, Family Member/Friend's Name:	Contact Information (Phone):
<p>We are interested in learning about the support you receive from other people.</p> <p>6. About how many close friends and close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?</p> <p>_____ (write in the number of close friends and close relatives)</p>				

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Please circle the number that best corresponds to your experiences.	None of the time	A Little of the time	Some of the time	Most of the time	All of the time
7. Someone to help you if you were confined to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Someone to take you to the doctor if you need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Someone to share your most private worries and fears with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Someone to turn to for suggestions about how to deal with a personal problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Someone to do something enjoyable with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Someone to love and make you feel wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Someone to talk story with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I would also like to ask you about other support available to you. In the last 30 days, how often have you participated in the following activities?					
a. Visited a community of faith or spirituality (e.g., church, temple, meditation group, etc.)?			_____ Number of Days		
b. Been active with a community activity group (e.g., sports, art, music, writing, etc.)?			_____ Number of Days		
c. Conducted recreation activities on your own (e.g., sports, art, music, writing, etc.)?			_____ Number of Days		
d. Participated in support groups (e.g., AA, parenting, mental health, etc.)?			_____ Number of Days		

Part VII: Monetary, Housing, and Vocational Readiness Resources

MONETARY ASSESSMENT			
1. Anticipated Total Net Monthly Income \$ _____	2. Anticipated Amount Available for Rent \$ _____	3. Is Member receiving SSI/SSDI? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Is Member receiving TANF? <input type="checkbox"/> Yes <input type="checkbox"/> No

DOCUMENTATION ASSESSMENT			
5. Member has access to the following documents:			Notes:
Government issued picture identification	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Social security card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Birth certificate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Proof of income letter from social security	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Current bank statements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other income and asset information	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
OTHER RISKS AND CONCERNS			
6. Does the member have a criminal history?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Part VIII: Goals, Challenges, and Strengths

1. What are your housing and non-housing goals? (Complete during initial assessment and if any of the goals are revised)				
Housing or Non-Housing Goal	Goal	What would achieving this goal look like?	How important is this goal?	How difficult is this goal?
			<i>(Not at all; A little; Moderately; Very)</i>	

1.b. How would you rate your progress on your housing and non-housing goals toward your expected outcome over the past 3 months? **(Complete at each re-assessment on all selected goals)**

Housing or Non-Housing Goal	Goal	Got Worse	No Change	Partially Achieved	Achieved as Expected	Achieved a little more than Expected	Achieved a lot more than Expected

2. What are your daily challenges?

Financial/Housing	Healthcare	Other
<ul style="list-style-type: none"> • Paying rent/utilities 	<ul style="list-style-type: none"> • Securing/Maintaining Medicaid Eligibility 	<ul style="list-style-type: none"> • Caregiving for children or other relatives
<ul style="list-style-type: none"> • Money management 	<ul style="list-style-type: none"> • Accessing health services 	<ul style="list-style-type: none"> • Personal Care
<ul style="list-style-type: none"> • Paying off debt 	<ul style="list-style-type: none"> • Accessing mental health services 	<ul style="list-style-type: none"> • Accessing health food

• Shopping for food/necessities	• Understanding doctor's orders	• Cooking
• Finding accessible/affordable housing	• Filling prescriptions	• Finding social support
• Finding work or training	• Taking medication as prescribed	• Transportation
• Other	• Other	• Other

3. What are your strengths? You might say things like 'supporting my friends,' qualities like sense of humor or resourcefulness, or share talents or skills that you have."

4. What are your hobbies or interests?

Part IX: Connection to Available Resources

Please check which of the follow services have you used in the last 30 days and which services you feel you need.			
Services	I USED this service	I currently NEED this service	I am not interested in this service
1. Financial help for first month's rent, utilities, or other one-time costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ongoing rent subsidy to afford housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Rental housing information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Help finding housing that meets my/my family's needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Legal assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Landlord mediation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Budgeting Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Soup kitchen or food pantry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Clothes closet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. ID assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Job readiness, job search, or employment assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Transportation assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Day center with telephones, mailrooms, or restrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Disability services, including SSI and SSDI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Medical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Permanent housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Transitional housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Emergency shelter/ temp housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Substance abuse treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Assistance with submitting Medicaid eligibility documents on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please list any other services you used or still need:			
Used:			
Need:			

Part X: Additional Considerations

Notes or Information from Any Additional Persons Engaged in this Assessment:

Signatures

The information in this assessment was collected in good faith and the information contained in this assessment is as accurate as possible.

_____ Member Signature	_____ Member Advocate Signature (if applicable)	_____ Date
_____ CIS Interviewer Signature	_____ CIS Interviewer Name & Title	_____ Date

SECTION B: INTERVIEWER ASSESSMENT OF MEMBER

Part XI: Interviewer Notes and Observations

Is the member in immediate danger to themselves or poses an immediate danger to others due to: <input type="checkbox"/> Suicidal Plan <input type="checkbox"/> Threat to Others <input type="checkbox"/> Medical Threat to Self	YES	<input type="checkbox"/>
If yes, ACTION PLAN:		
Does the member need urgent attention for a physical health need?	YES	<input type="checkbox"/>
If yes, ACTION PLAN:		

Does the member need urgent attention for a behavioral health need?				YES	<input type="checkbox"/>
If yes, ACTION PLAN:					
Has this member been assessed for Long-Term Services and Supports (LTSS)?	<input type="checkbox"/> No, but the member is a good candidate for LTSS	<input type="checkbox"/> No, but the member is not a good candidate	<input type="checkbox"/> Yes, the member is awaiting services	<input type="checkbox"/> Yes, the member is currently receiving services	
Has this member been assessed for Special Health Care Needs (SHCN)?	<input type="checkbox"/> No, but the member is a good candidate for SHCN	<input type="checkbox"/> No, but the member is not a good candidate	<input type="checkbox"/> Yes, the member is awaiting services	<input type="checkbox"/> Yes, the member is currently receiving services	
Has this member been assessed for Community Care Services (CCS)?	<input type="checkbox"/> No, but the member is a good candidate for CCS	<input type="checkbox"/> No, but the member is not a good candidate	<input type="checkbox"/> Yes, the member is awaiting services	<input type="checkbox"/> Yes, the member is currently receiving services	

Other Interviewer Notes and Observations:

Part XII: CIS Acuity Score Calculation (PLEASE SCORE MEMBER'S RESPONSES BELOW)

Question	If Response was...	Max. Points	Score
1. General health in the past 30 days	Poor or Fair	1	
2. Days physical health not good (PUD)	>14	1	
3. Days mental health not good (MUD)	>14	1	
4. Days poor health kept from usual activities (ACT)	>14	1	
5. Has at least two or physical conditions or disability	2+ Conditions or Disabilities	1	
6. Has at least two behavioral conditions (i.e. mental health or substance use disorder)	2+ Conditions or Disabilities	1	
5 & 6. BOTH physical condition(s)/disability AND behavioral condition(s)	1+ physical & 1+ behavioral condition	1	
7. Been physically hurt (violence to the member)	Sometimes, Fairly Often, Very Often	1	
8. Those close to member physically hurt (violence to those close)	Sometimes, Fairly Often, Very Often	1	
9. Been verbally hurt (verbal violence)	Sometimes, Fairly Often, Very Often	1	
10. Emotionally hurt or controlled (emotional violence or controlling)	Sometimes, Fairly Often, Very Often	1	
11. Feeling unsafe where currently living	Sometimes, Fairly Often, Very Often	1	
12. Having an encounter with the police	Yes	1	
13. Arrested or spent one or more days in jail	Yes	1	
14. Number of emergency room visits in the past 3 months	Total number; if 3+, give max score of 3	3	
15. Number of hospitalizations for a physical condition in the past 3 months	Total number; if 3+, give max score of 3	3	
16. Number of hospitalizations for a behavioral health condition in the past 3 months	Total number; if 3+, give max score of 3	3	
17. At least one stay in a crisis home or unit	Yes	1	
18. Alcohol consumption in the past 30 days	Everyday	1	
19. Drug use in the past 30 days	A couple times a week, everyday	1	
20. Visited a doctor for a routine checkup	2 yrs, 5 yrs, or 5+ yrs ago, DK	1	
21. Visited a mental health professional	2 yrs, 5 yrs, or 5+ yrs ago, DK	1	

22 & 23. Forgets or careless about taking medication (Unintentional non-adherence)	Yes to either	1	
24 & 25. Stops taking medications due do feeling better/worse (Intentional non-adherence)	Yes to either	1	
26 & 27. Difficulty picking up or taking prescribed medications	Yes to either	1	
28. Days lived outside in the past 30 days	>14	1	
29. Homelessness in the past 3 years	1+ times	1	
30. Length of most recent homelessness	1 year or more	1	
31. Ever been victim of human or sex trafficking	Yes	1	
32. Threat to self or others (TAKE IMMEDIATE ACTION)	Yes	3	
33. Homelessness caused by mental health disorder/substance abuse	Yes	1	
33b. Homelessness caused by physical health condition/disability	Yes	1	
¹ Scores > 11 must get flagged for possible crisis intervention	TOTAL MEMBER-ASSESSMENT ACUITY SCORE (Out of 40)¹		

Interviewer Name & Title:	
Interviewer Signature:	
Date:	

Initial HAP Date: / /

Member Name Member ID # HAP Date: / /
Lead Service Coordinator Phone
Name Number

Adult (18+)
CIS

SECTION A. AUTHORIZATION OF MY SUPPORT SERVICES		
A1. MEMBER/AUTHORIZED REPRESENTATIVE		
I have signed this document because I agree that: I/We have directed this service plan meeting as much as possible; information about all my available choices was provided and I/We made my own choices and decisions in this meeting; and I/We reviewed and agree to the support services written in my plan.		
<u> </u>	<u> </u>	<u> / / </u>
Print Member Name	Signature	Date
<u> </u>	<u> </u>	<u> / / </u>
Print Authorized Representative Name	Signature	Date
Indicate who directed the meeting. If someone other than the member directed the service plan meeting, explain why.		
<u> </u>		
A2. SERVICE COORDINATOR(S)		
<u> </u>	<u> </u>	<u> / / </u>
Print Lead Service Coordinator Name	Signature and Title	Date

<div style="border-bottom: 1px solid black; margin-bottom: 5px;"> </div>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"> </div>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"> / / </div>
Print Consulting Service Coordinator Name	Signature and Title	Date
A3. COPY OF PLAN GIVEN TO		
Primary Care Provider: 		
Support Provider(s): 		

SECTION B. MY GOALS, AND ACTIONS					
Housing or Non-Housing Goal	Goal	What would achieving this goal look like?	Plan to Support Member in Achieving This Goal	Support start date	Frequency/Amount/Duration of Services Planned
				/ /	
				/ /	
				/ /	
				/ /	
				/ /	
				/ /	
Other Service Activites Planned Related to Member Goal Planning:					

SECTION C. MY SUPPORT PLAN					
C6. Community Integration Services (CIS) N/A					
SERVICES	DESCRIPTION OF SERVICES THAT WILL BE PROVIDED	START DATE	PROVIDER(S)	FREQUENCY/AMOUNT	DURATION
C.6.A. Housing Supports					
Referral to emergency shelter/temporary housing		/ /			
Housing assistance (Rental information, applications, etc.)		/ /			
Referral to transitional housing		/ /			
Referral to housing vouchers/ intermediate housing resources		/ /			
Referral to permanent/long-term housing resources		/ /			
Housing related accessibility needs		/ /			
Landlord mediation/advocacy		/ /			
Other housing related supports:		/ /			
C.6.B. Medical Re-Engagement and Care Coordination Supports					
Hospital or urgent care assistance for urgent medical attention		/ /			
Engagement/re-engagement with primary care team		/ /			
Referral to behavioral health provider(s)		/ /			
Engagement in Substance Use Treatment		/ /			

Engagement in Medication Assisted Treatment		/ /			
Referral to other specialist(s). List:		/ /			
Support with picking up medications		/ /			
Referral for medication reconciliation and MTM		/ /			
Other Medical Supports:		/ /			
C.6.C. QUEST and Other DOH Program Referral Supports					
Assistance with submitting Medicaid Eligibility Documents on time		/ /			
Referral to CCS		/ /			
Referral to LTSS		/ /			
Referral to SHCN/EHCN		/ /			
Adult Protective Services		/ /			
I/DD Program (DOH)		/ /			
ADAD/AMHD Programs (DOH)		/ /			
Other QUEST or DOH Programs:		/ /			
C.6.D. Safety Supports					
Address threat to self or others (immediate action)		/ /			

Personal safety issues/referral to violence shelters		/ /			
DHS Adult Protective Services		/ /			
Other Safety Supports:		/ /			
C.6.E. Supports to Address Social Risk Factors					
Soup kitchen or food pantry		/ /			
Transportation resource/assistance		/ /			
Clothes closet		/ /			
Re-engagement in social communities		/ /			
Other SDOH Needs:		/ /			
C.6.F. Financial Assistance Supports					
Application for disability		/ /			
Application for TANF		/ /			
Application for SNAP		/ /			
Budgeting Assistance		/ /			
Financial help for first month's rent, utilities, or other one-time costs		/ /			
Other financial supports:		/ /			
C.6.G. Employment and Housing Readiness Supports					
ID/documentation assistance		/ /			

Legal encumbrance/referral to legal assistance or services		/ /			
Job readiness, job search, or employment assistance		/ /			
DHS Vocational Rehabilitation Program		/ /			
Other Employment Supports:		/ /			
Other Housing Readiness Supports:		/ /			
C.6.H. Other Supports Not Identified Elsewhere					
Access to communication supports (telephone, etc.)		/ /			
Day center with telephones, mailrooms, or restrooms		/ /			
Other needed supports not categorized elsewhere:		/ /			
Other needed supports not categorized elsewhere:		/ /			

SECTION H. MEMBER CRISIS PLAN			
Member Triggers	Actions Member will take When Triggered	People Member will Reach Out To	Provider or Health Plan Responsibilities in case of crisis
SECTION I. MEMBER EVICTION PREVENTION PLAN			
Member Triggers	Actions Member will take When Triggered	People Member will Reach Out To	Provider or Health Plan Responsibilities in case of crisis
SECTION H. ADDITIONAL COMMENTS			

Member Signature	Member Advocate Signature (if applicable)	Date
CIS Plan Preparer/Reviewer Signature	CIS Plan Preparer/Reviewer Name & Title	Date

Paid by HPO Funding:

Paid by CIS Funding:

- Rental subsidies
- Outreach services at every stage for a non-Medicaid eligible member.
- Security deposits
- Landlord incentives, signing incentives, and mitigation for repairs
- Eligibility confirmations for HMIS members, using VISPDAT and homelessness definitions to prove eligibility
- State-wide or CoC wide Risk Mitigation Fund for landlords
- Moving supports (moving costs and moving help if no company is available to hire)
- Welcome Home supplies/baskets
- Furniture
- HMIS documentation time
- HUD reporting and administrative requirements
- Inclusion with CIS provider (if not same agency) at assessment and service planning meetings (warm hand offs to CIS provider if not CES providers)
- Pre-tenancy and tenancy sustaining services for non-CIS eligible participants

- Outreach, referral, obtaining consent, and Assessment of a Medicaid eligible member
- Coordination with CES providers and referring agency (hospital, etc.)
- Pre-Tenancy Services
- Tenancy-Sustaining Services
- Re-assessment and reauthorization activities

HCBS members will have the right to:

- A lease or legally enforceable agreement that provides member with the same responsibilities and protection from eviction that tenants have under landlord tenant law;
- Privacy in member's living unit, including a lock on your door, with only appropriate staff having keys to doors, as needed, for safety checks;
- A choice of roommates, if member chooses to have a roommate;
- Decorate their living unit within the parameters of the lease agreement;
- Control their schedule and choose the activities to participate in;
- Have visitors when member chooses; and
- A setting that is physically accessible to the member and optimizes but does not regiment member initiative, autonomy, and independence in making life choices.

Before a members' rights are changed, the CIS housing provider or Health Plan must:

- Obtain member's consent to make a change to member's rights;
- Discuss with member, the specific assessed need or condition that the change is based on;
- Try positive interventions and less intrusive ways to deal with the specific assessed need and then review these with member;
- Document the discussion, the change(s) to be made and data to measure the ongoing effectiveness of the modification;
- Assure that the intervention and supports will cause no harm to the member; and
- Provide this documentation to member and QI service coordinator.

Signature: 

Email: jmohrpeterson@dhs.hawaii.gov