TRANSITIONAL RENT AUTHORIZATION FORM

Transitional Rent provides up to six months of rental assistance in interim and permanent settings to members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care) or who meet other specified eligibility criteria.

For more information, please review Health Net's **Authorization Guide for Transitional Rent** and the Department of Health Care Services (DHCS) **Community Supports Policy Guide Vol. 2**, updated April 2025.

Initial attestation

☐ Has the member consented to the Transitional Rent authorization request? ☐Yes ☐No

Date member consented: _____

- ❑ Is the member Behavioral Health Services Act (BHSA)-eligible? ☐Yes ☐No
- ❑ Will the member be able to transition to a BHSA Housing Intervention or housing subsidy at the expiration of Transitional Rent? Yes No
- ❑ Is the member's Housing Support Plan included with this authorization request? Yes No
- ❑ Is the member experiencing homelessness or at risk of homelessness? Yes No

DO NOT submit this authorization form if you have responded NO to any of the questions above.

Behavioral health streamline authorization attestation (contracted behavioral health providers only)

☐ The county behavioral health agency is contracted with the member's health plan as a Transitional Rent provider.

☐ The county behavioral health agency determines that the member is BHSA-eligible and commits to providing the member with BHSA Housing Interventions at the expiration of Transitional Rent or upon denial of the request for coverage by the health plan.

☐ The county behavioral health agency commits to sending a referral and request for authorization to the health plan within 14 days of the county behavioral health agency's streamlined provisional authorization.

Date Provisional Authorization was made by behavioral health Transitional Rent provider: _____

Behavioral health Transitional Rent provider name/title: _____

Behavioral health Transitional Rent provider signature: _____

***Upon agreement with the Managed Care Plan, the county behavioral health agency may delegate this authority to another organization, including, but not limited to, a Flex Pool.**

Behavioral health population of focus eligibility

Member meets the access criteria for Medi-Cal Specialty Mental Health Service (SMHS), Drug Medi-Cal (DMC) or Drug Medical Organized Delivery System (DMC-ODS). Check all that apply:

- ❑ Member is already receiving or has a history of receiving services in the past 12 months through the SMHS/DMC/DMC-ODS delivery systems.
- ❑ Member has utilization of services in either the Managed Care Plan and/or the SMHS/DMC/DMC-ODS delivery systems that indicates the likelihood of SMHS/SUD access criteria.

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- ❑ Member has been referred to the SMHS/DMC/DMC-ODS delivery systems (including members screened[1] by their Managed Care Plan and referred to the other delivery systems).
- ❑ Member is receiving Enhanced Care Management (ECM) and meets the "SMH and/or Substance Use Disorder (SUD) Needs" population of focus.
- ❑ Referral is from a qualified health professional who is serving the member or served the member in the last 12 months and has determined that the member has ongoing behavioral health/SUD needs that meet the access criteria.

Please submit any additional supporting documentation describing the member's behavioral health needs with the authorization form. Health Net may request additional information, if necessary, to validate member eligibility.

- **Documentation supporting the member's behavioral health condition or SUD needs, from treating primary care physician, specialist or mental health provider**
- **Chart notes**
- **Social worker notes, nurse progress notes, paramedic notes**

Eligibility criteria

Members are eligible for Transitional Rent if they meet <u>all</u> of the following criteria:**

☐ (1) **Clinical risk factor requirement:** Must have one or more of the following qualifying clinical risk factors:
- ☐ (i) Meets the access criteria for SMHS
- ☐ (ii) Meets the access criteria for DMC or DMC-ODS

AND

☐ (2) **Social risk factor requirement**: Experiencing or at risk of homelessness

AND

☐ (3) **Individual must meet one of the following requirements from a, b or c:**

a) Transitioning Population Requirement**:**
- ☐ Transitioning out of an institutional or congregate residential setting
- ☐ Transitioning out of a carceral setting
- ☐ Transitioning out of interim housing
- ☐ Transitioning out of Recuperative Care or Short-Term Post-Hospitalization Housing
- ☐ Transitioning out of foster care

OR

b) ☐ Experiencing unsheltered homelessness

OR

c) ☐ Eligible for Full-Service Partnership (FSP)

****See CS Authorization Guide for Transitional Rent for additional details on Transitional Rent eligibility.**

Member information

Member name:	**Date of birth**:
Medi-Cal ID number:	**Preferred language:**
Home address:	**Phone number:**
Contact name (if different than the member):	**Relationship:**
Phone number:	**Preferred language:**
Email address:	

Community Supports provider information (servicing organization)	
Organization name:	
Tax identification number (TIN):	**National provider identifier (NPI):**
Staff name:	**Title:**
Phone number:	**Fax number:**
Staff email address:	

Referral information (referring entity)	
☐ **Check this box if referring entity is the same as the Community Supports provider.**	
Name:	
Tax ID/NPI:	
Address:	**Phone number:**
Email address:	**Fax number:**
Relationship to the member:	

Interim housing setting attestation

Transitional Rent providers must attest to all of the following:

☐ The Transitional Rent provider confirms with the member's county behavioral health agency that the member is BHSA-eligible[1] and will be able to transition to BHSA housing interventions at the expiration of Transitional Rent, if the member is otherwise not able to secure a U.S. Housing and Urban Development (HUD) Housing Choice Voucher, permanent supportive housing subsidy, or other long-term rental subsidy to transition to at the expiration of coverage under Transitional Rent.

☐ This confirmation from the county behavioral health agency is documented in the member's Housing Support Plan.

Transitional Rent provider name/title: _____
Transitional Rent provider signature: _____

Note: This section is required for all interim setting authorizations.

Additional eligibility criteria

1. **Has the member utilized Recuperative Care, Short-Term Post-Hospitalization Housing or Transitional Rent with Health Net or any other Managed Care Plan once within the demonstration period[2]?**

☐ Yes ☐ No ☐ Unsure

[1]There is a very small population that will fall into the Transitional Rent Behavioral Health population of focus but may not meet the BHSA eligibility criteria or be covered for BHSA Housing Interventions in a particular county. This is because an individual with a mild SUD will meet the clinical criteria for inclusion in the Behavioral Health population of focus, and thus could be included in this population of focus if the other eligibility requirements were met, but may not be eligible for BHSA services. Under the BHSA, eligibility on the basis of an SUD is limited to those with a moderate to severe SUD (see W&I Code sections 5830(a)(1), 5892(k)(7), 5891.5(c)). In addition, counties have the option but are not required to provide Housing Interventions to an individual with an SUD only (see W&I Code section 5891.5(a)(2)). If an individual falls within the Behavioral Health population of focus and the county behavioral health agency determines that the individual is not BHSA-eligible (e.g., because they have a mild SUD only) or not eligible for BHSA Housing Interventions (e.g., because the county has declined to provide Housing Interventions to individuals with an SUD), the Managed Care Plan must determine that the member has an alternative subsidy to transition to at the expiration of six months of transitional rent, such as HUD-assisted housing, prior to authorizing transitional rent for an interim setting.

[2]The demonstration period is once per five years.

If yes, how many total days did the member receive these services? _____

Which health plan(s)? _____

**Transitional Rent cannot exceed a duration of six months or 182 days per rolling 12-month period (but may be authorized for a shorter period based on individual needs) and is subject to the six months or 182 days global cap on room and board services.*[3]

Required documentation

☐ Permanent Housing: Lease agreement/Intent to Rent

☐ Interim Housing: Bed/Room agreement or equivalent

☐ Transitional Population: Documentation of date of the transition event (discharge date, date of release)

☐ Housing inspection form

☐ Housing Support Plan: Attach member's Housing Support Plan that explicitly outlines the following:

- ☐ Identify the permanent housing strategy, including the payment sources that will support the member in maintaining housing after Transitional Rent benefits are exhausted **(must document the member's income, BHSA Housing Voucher or other long-term subsidies)**.
- ☐ The full range of housing supports that will support the member in sustaining tenancy (e.g., tenancy sustaining service, utilities).
- ☐ The Housing Support Plan must be informed by member preferences and needs and reviewed and revised as needed based on changes in member circumstances.

Note: Upon move-in, Transitional Rent must be requested within 30 calendar days of the move-in date listed on the lease agreement or interim setting agreement.

Housing setting information		
Move-in date:		
Unit rate:[4]	**Interim (daily rate): $**	**Permanent (monthly rent): $**

The payment provided to the Transitional Rent provider is designed to cover the full cost of rent or housing for the member and can only include:

» Rental assistance in allowable settings.

» Storage fees, amenity fees and landlord-paid utilities that are charged as part of the rent payment.

Note: If the unit rate exceeds the monthly reimbursable ceilings, the authorization request is subject to denial unless the provider is able to negotiate the rent or temporary housing costs to align with the established reimbursable limits.[5]

[3] A "global cap" on coverage of Short-Term Post Hospitalization Housing, Recuperative Care, and Transitional Rent, all three of which are referred to as "room and board" services. Under the cap, coverage is limited to six months of room and board services per member within a rolling 12- month period. This means that a member may not receive more than a combined six months of Short-Term Post-Hospitalization Housing, Recuperative Care and Transitional Rent during any rolling 12-month period. The 12-month rolling timeframe begins on the first day the member uses any of these services.

[4] The Transitional Rent payment is designed to cover the cost of rent or temporary housing for the member for the full time in which the member is receiving Transitional Rent (which may be up to six months). Managed Care Plans and Transitional Rent providers must not require members receiving Transitional Rent to cover a share of the rent. Managed Care Plans and Transitional Rent providers should place members in settings where the payment provided by the Transitional Rent Provider to the landlord or property owner is sufficient. The reimbursable ceilings are tied to a percentage of the HUD Small Area Fair Market Rents (SAFMR). See HUD's SAFMR available here: https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2025_code/select_Geography_sa.odn.

[5] https://www.dhcs.ca.gov/services/Documents/DirectedPymts/CY-2025-Transitional-Rent-Payment-Model.pdf.

Select the housing setting the member is moving into			
Service type	Setting type description	Bedroom size	ZIP code
☐ Permanent	Allowable permanent setting (Not single room occupancy)	❑ Efficiency ❑ 1 ❑ 2 ❑ 3 ❑ 4	
☐ Permanent	Single room occupancy	❑ Single Room	
☐ Permanent	Shared housing where two or more people live in one rental unit	❑ One bedroom in shared two bedroom ❑ One bedroom in shared three bedroom ❑ One bedroom in shared four bedroom ❑ Two bedrooms in shared three bedroom ❑ Two bedrooms in shared four bedroom ❑ Three bedroom in shared four bedroom	

Service type	Setting type description	Bedroom size	ZIP code
☐ Interim	Interim setting when a member has their own room	❑ Efficiency ❑ 1 ❑ 2 ❑ 3 ❑ 4	
☐ Interim	Interim setting with a small number of individuals per room	❑ One bed occupied where two beds available ❑ One bed occupied where three beds available ❑ One bed occupied where four beds available ❑ Two beds occupied where two beds available ❑ Two beds occupied where three beds available ❑ Two beds occupied where four beds available ❑ Three beds occupied where three beds available ❑ Three beds occupied where four beds available ❑ Four beds occupied where four beds available	

Member household **Please identify the household composition**			
☐ Single adult member	☐ Adult member and family	☐ Minors and family	☐ Single minor member
☐ Adult member with partner/spouse (no children)	☐ Adult member with other occupant(s) (non-family)	☐ Minor member with other occupant(s) (non-family)	

Household **Please list all individuals living in household**		
Name of individual in household	**Date of birth**	**Medi-Cal number (CIN)**

Additional comments: