Transitional Rent Referral Form

Transitional Rent (TR) provides rental assistance in interim or permanent settings to eligible Blue Shield of California Promise Health Plan members. As one of the Room and Board services, Transitional Rent is subject to a global cap: **members may not receive more than six months (182 days) of Room and Board services per rolling 12-month period.** If more than one person in a household qualifies, the global cap of 182 days applies to the entire household. For more information about Transitional Rent, see the DHCS Community Supports Policy Guide Volume 2.

Please send the completed form or any questions by Secure email to CommunitySupports@blueshieldca.com.

Section A – Eligibility ***All fields are required unless marked "optional."**

Today's date:	
Blue Shield Promise Member ID #:	Medi-Cal CIN:

Please check the TR service type being requested:

- ◯ Transitional Rent Interim Setting ◯ Transitional Rent Permanent Setting
- ☐ Member is receiving TR and is transitioning from one setting to another

Eligibility criteria (Check all that apply. Must meet all 5 requirements.)

- ☐ 1. Medi-Cal member is enrolled with Blue Shield of California Promise Health Plan. (See member ID above.)

Member meets TR Behavioral Health Population of Focus Eligibility requirements:

- ☐ 2. **Clinical Risk Factor** (one or more) – Please attach required documentation or attestation.
  - ☐ Member meets the criteria for Medi-Cal Specialty Mental Health Services (SMHS).
  - ☐ Member meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS).
- ☐ 3. **Social Risk Factor** – By checking this box, you attest that, according to the DHCS Community Supports Policy Guide, Appendix C, Definition of Experiencing or at Risk of Homelessness:
  - ☐ Member is experiencing homelessness.
  - ☐ Member is at risk of homelessness.
- ☐ 4. **Transitioning Population** – By checking this box, you attest the member is:
  - ☐ 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.
  - ☐ Experiencing unsheltered homelessness.
  - ☐ Eligible for Full-Service Partnership (FSP).
- ☐ 5. Funding for housing is available after TR ends. Please attach required documentation.
  - ◯ Member is eligible under the Behavioral Health Services Act (BHSA) and will be able to transition to a BHSA Housing Intervention or housing subsidy when TR ends. (Required for interim settings.)
  - ◯ Member is not BHSA-eligible, but will be able to transition to an alternative subsidy.

Section B – Member information

First name:	Last name:
Date of birth:	Start date of TR services:
Member phone number:	Member email:

Optional

Preferred contact method:	Preferred language:	
Alternate contact:	Gender:	
Current street address:	City:	ZIP code:
Primary care physician:		
Homeless Management Information System (HMIS) client ID number:		

Is the member currently enrolled in any of the following programs? (Check all that apply.)

☐ Enhanced Care Management (ECM) – If yes, which provider?
If no, please indicate the member's ECM status:
- ◯ Member declined ECM services.
- ◯ ECM referral submitted.
- ◯ ECM outreach not yet initiated.

☐ Housing Navigation – If yes, which provider?
If no, has a service authorization been submitted? ◯ Yes ◯ No

☐ Tenancy Sustaining Services – If yes, which provider?
If no, has a service authorization been submitted? ◯ Yes ◯ No

☐ Housing Deposits – If yes, which provider?
If no, has a service authorization been submitted? ◯ Yes ◯ No

Section C – Referrer information

Name:	Referrer's email:	
Referrer's phone number:	Referrer's fax number:	
Referrer's address:	City:	ZIP code:
Organization:	NPI#:	
Referrer's relationship to member: ◯ Medical provider ◯ Social Services provider ◯ Member ◯ Family ◯ Other:		

Optional

Alternate contact name:	
Alternate contact's phone number:	Alternate contact's email:
Alternate's relationship to member: ◯ Medical provider ◯ Social Services provider ◯ Member ◯ Family ◯ Other:	
Additional comments from referrer:	