Authorization Guide for Housing Transition Navigation Services

Housing Transition Navigation services assist members with obtaining housing.

Service duration can be as long as necessary. Initial authorization is for a period of 12 months. Extensions are allowed after the initial 12 months in 6-month increments based on medical necessity.

Members must meet the following criteria to qualify for housing transition navigation services:

<table>
<tr><td colspan="2">Eligibility</td></tr>
<tr><td colspan="2">• Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration; or
• Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder[1]; or
Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations: (see page 2).</td></tr>
<tr><td colspan="2">Restrictions</td></tr>
<tr><td colspan="2">• Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.
• Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other state, local, or federally funded programs.</td></tr>
<tr><td colspan="2">Services include:</td></tr>
<tr><td>• Tenant screening and housing assessment that identifies the member’s preferences and barriers related to successful tenancy.
• Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member’s approach to meeting the goals, and identifies when other providers or services are needed.</td><td>• Assisting with requests for reasonable accommodation, if necessary.
• Educating and engaging with landlords.
• Ensuring that the living environment is safe and ready for move in.
• Communicating and advocating on behalf of the member with landlords.
• Assisting with arranging for and supporting the details of the move. Provided to members on site in the recuperative care facility.</td></tr>
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[1] **Examples of qualifying institutionalization or residential services:** hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, institutions for mental diseases, and state hospitals.

Services include, continued:

- Searching for housing and presenting options.
- Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
- Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process.
- Identifying and securing available resources to assist with subsidizing rent and matching available rental subsidy resources to members.
- Identifying and securing resources to cover expenses. [2]
- Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
- Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
- Identifying and coordinating environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations Community Support).

Total lifetime maximum: N/A

Codes:

- H0043 U6 Supported housing per diem.
- Do not use H2016 Comprehensive Community support services per diem.

Unit of Service:

- Per Diem

Allowable Community Support providers:

Providers must have experience and expertise with providing housing-related services and supports in a culturally and linguistically appropriate manner. Provider must use best practices in rendering services. [3]

Section 91.5 of Title 24 of the Code of Federal Regulations:

1. An individual or family who:
   - Has an annual income below 30 percent of median family income for the area, as determined by HUD.
   - 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 an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
     - Meets one of the following conditions:
       - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
       - Is living in the home of another because of economic hardship;
       - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

[2] **One-time expenses**: Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

[3] **Examples of possible providers**: Vocational services agencies, providers of services for individuals experiencing homelessness, life skills training and education providers, county agencies, public hospital systems, mental health or substance use disorder treatment providers, including county behavioral health agencies, social services agencies, affordable housing providers, supportive housing providers, federally qualified health centers and rural health clinics.

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, state, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.

2. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
3. A child or youth who does not qualify as "homeless" under this section but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.
4. Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
   - Have one or more serious chronic conditions;
   - Have a serious mental illness;
   - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);
   - Are receiving Enhanced Care Management; or
   - Are a transition-age youth with significant barriers to housing stability.[4]

[4]**Examples of Transition-Age Youth with significant barriers to housing stability**: one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have serious mental illness and/or are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.