**Rapid Transition Housing Program Referral Form**

The Rapid Transition Housing Program (RTHP) provides a rental subsidy and community transition services for high-cost, high-need Medicaid beneficiaries. Eligibility for the program includes: Medicaid members with one or more documented chronic physical disabilities and have two or more chronic conditions (e.g., asthma, diabetes), and are referred as homeless high-utilizers\* by a hospital, Managed Care Organization (MCO), medical respite, Performing Provider System (PPS), or Skilled Nursing Facility (SNF). Priority will be given to those who are awaiting an organ transplant and need emergency housing to meet waitlist requirements.

This form is to be completed by the referral source with the participant being referred. The individual will be contacted directly by an RTHP Housing Specialist for eligibility screening and enrollment.

|  |
| --- |
| Referral Information |

**□ Priority: Transplant list participant and need housing to meet the waitlist requirements.**

Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid: □ Yes □ No □ Applied (date) \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ CIN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MMCO Care Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Home Care Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Location (e.g., nursing home, homeless shelter):

Do you have a Legal Guardian: □ Yes □ No Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Referral Source |

□ Article 28/31 Hospital (Hospital) □ Managed Care Organization (MCO)

□ Medical Respite □ Performing Provider System (PPS)

□ Skilled Nursing Facility (SNF)

Contact Name and Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Documentation needed to meet eligibility:**

* E-paces showing active Medicaid
* Written verification of physical disability & two chronic conditions by an MD.
* Proof of homelessness/ unstably housed
* Proof of identity
* Current Award letter/income statements to meet HUD FY Extremely Low Income
* Proof of ED visits/ hospitalizations/SNF stay to show high utilization\*

\*Defined as:

1. Having two or more inpatient stays in the past 12 months; or

2. Having five or more emergency department (ED) visits in the past 12 months; or

3. Having four or more ED visits and one or more inpatient stay in the past 12 months; or

4. Having stayed or currently in a SNF within the past 12 Months; Or

5. Be within the top 20% of Medicaid recipients’ spending relative to the county of fiscal responsibility and target

population parameters (e.g., an asthma recipient in Westchester has base period spending of more than 80% of the asthma Medicaid population in that county).