Home Stabilization Prior Authorization Request Form

Home Stabilization services are for Medicaid beneficiaries who require support in maintaining a home and do not currently receive home-based case management through another Federally funded program administered by the State. These services consist of two distinct set of services: home find and tenancy support. The services are intended to be time-limited, promote stability, and help people find a home (home find) and maintain housing (tenancy support). The Home Stabilization services are not designed to supplant specialized case management or care coordination.

Name of Person Making Request: _____ Phone: _____

Agency/Relationship: _____ Email_____

Participant's Name: _____
D.O.B.: _____ MID (10 digit): _____
Address: _____ City: _____ Zip Code: _____

Does Participant live(check one): Alone With Others, please specify _____

Brief Description of Participant's Circumstances:

Current Housing Situation: Check the box under the service requested (tenancy or home find)

Currently, participant lives in:	**Tenancy Services**	**Home Find**
Apartment or home, rented or owned by participant		
Transitional or temporary housing		
Institution Expected date to move to home setting, if applicable: _____		
Homeless or other emergency shelter or place not meant for habitation		

Eligibility: Check all that apply

I attest that the participant I am referring meets at least one of the following health-based criteria AND at least one of the housing-related criteria. I understand that I must keep documentation demonstrating the criteria that are indicated and may be required to furnish proof upon request.

Health: Currently, participant is assessed to have (check all that apply):

A 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 mental illness	
Any 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 ability to live independently without support).	

AND

Housing: Currently, participant has (check all that apply):

History of eviction and/or unstable housing (an individual must establish one of the following: notices from landlords/housing authorities to resolve issues, month-to-month housing agreements, couch surfing arrangements, or housing costs exceeding income /resources).	
History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized 3 or more different in-home caregiver provider agencies and the current placement is not appropriate for the individual.	
History of institutionalization in a medical or penal facility including hospitals, Intermediate Care Facilities for People with Intellectual Disability (ICF/ID), skilled nursing facilities, penal institutions nursing homes, Nursing Homes or other LTC housing, state hospitals, and any correctional facilities.	
Past or present substance use that interfered with ability to pay rent, maintain apartment according to lease, or created interpersonal issues that jeopardized housing.	

For State Staff Use Only:
Reviewed by: _____ *Date:* _____
Decision:
☐ *Approved* *Prior Authorization #:* _____ *Start Date:* _____ *End Date:* _____
☐ *Not eligible*
Date Referral Form and Prior Authorization Form Received at EOHHS: _____

Signature Print Name Date