Rhode Island Executive Office of Health and Human Services
74 West Road, Cranston, RI 02920

Home Stabilization Referral 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 with different eligibility, service definitions and criteria: 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 Referral: _____ Phone: _____

Agency/Relationship: _____ Email: _____

Participant's Name: _____

D.O.B.: _____ MID (10 digit): _____

Address: _____ City: _____ Zip Code: _____

Does participant live (circle 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 *(**participant must be in a home at time tenancy services are rendered**)* Expected date to move to home setting: _____	☐	☐
Homeless or other emergency shelter		☐

Eligibility: Check all that apply

I attest that the participant I am referring meets one of the following criteria. I understand that I may be required to furnish proof upon request.

History of Homelessness**	☐
At Risk of Homelessness or Current Tenancy is in Jeopardy *(**Example: non-payment of rent, repeated episodes of conflict in the housing community substantiated by a housing or health care provider**)*	☐
Transitioning from Institutionalization > 90 days	☐

***Definition of homeless or at-risk of homelessness is defined for children by the McKinney-Vento Assistance Act and the HEARTH Act of 2009 for adults.*

_____

Signature Print Name Date

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: _____