Full Life Care Foundational Community Supports
Supportive Housing Referral Instructions

Please send complete Foundational Community Supports (FCS) Supportive Housing referral forms to fcsreferrals@fulllifecare.org for review and processing.

For referral to Foundational Community Supports, you must complete the following:

1. **Required Sections**
   - Date (include **ONLY** if you complete **ALL** sections of the form. *See note below.)
   - Name
   - ProviderOne ID
   - Date of Birth (DOB)
   - Address (if homeless, street address not required but please list city, state, zip code if possible)
   - Phone Number, as applicable
   - Email address, as applicable
   - Referring provider name and agency, as applicable
   - Part A on pages 1 and 2 (see Part A Guidance below)
   - Signature section on page 6
     - Name of the person completing the assessment
     - Agency and Title or relationship with referred individual
     - Date of signature
     - Signature (electronic signature is OK)
     - Enrollee Name
     - Enrollee Signature (please note if enrollee verbally consented in signature field)
     - Date of provided enrollee consent

   * ***Note:*** *ONLY include the date if you fully complete the form—Parts A and B. Referral forms dated more than 10 days ago are denied. If you are only completing Part A, do not include the date in the Top Section.* Once you submit the form, Full Life Care Foundational Community Supports case managers will take steps to complete the form and will include the date of finalizing the details to assure smooth intake via Amerigroup authorizing system.

2. **Part A "Complex Needs Eligibility Requirements" Guidance for Referrer**
   a. You MUST select at least one item under "Health Need" AND one item under "Risk Factor" eligibility section for referred individual to potentially qualify.
   b. It is not required to list qualifying sources for ***each*** criterion unless readily available, but any anecdotal information or self-reported information from referred individual is helpful.

        i. For example: proof of Coordinated Entry Assessment for "homeless individual with disability" criterion is not required, but please note if Coordinated Entry Assessment was completed, if applicable.
    c. Select any items that apply and provide supportive information in the "Details" section at end of Part A on page 2.
        i. Information may be anecdotal or per referred individual self-report.

3. **PRISM Score (Final possible criterion under "Risk Factor" section)**
    a. a. If the PRISM Score is known, check box and input score in "Additional details on risk factors" open text box that is directly below PRISM score criterion.
    b. If the PRISM Score is unknown, send the form and note in body of submission email that assistance is needed to identify PRISM risk score.

4. **Part B Guidance for Referrer: Housing Assessment**
    a. Completing Part B, through page 5, is not required for referral. However any information is helpful.

5. **Submission and Authorization**
    a. Email the form to fcsreferrals@fulllifecare.org.
    b. Submit the form to Full Life Care Foundational Community Supports referrals as soon as possible to allow time for processing prior to submission to Amerigroup for final review and authorization.
    c. Once referral form is sent to Amerigroup, there is a five business day turnaround for authorization.
    d. Upon receipt of Amerigroup authorization, Full Life Care Foundational Community Supports referral coordination staff will be in touch with housing case manager staffing timeline and any additional information or questions.
    e. Upon authorization, a Foundational Community Supports housing case manager will review Part B and complete in full as part of initial assessment meeting with client.

For any questions regarding potential referral, referral form or process, please contact us.

Full Life Care Foundational Community Supports
Referral Inbox: fcsreferrals@fulllifecare.org
Main Line: 206.231.0202

Amerigroup
An Anthem Company

https://providers.amerigroup.com

Foundational Community Supports: Supportive Housing Assessment

☐ Initial assessment ☐ Reauthorization

**Indicates a required field.*

***Date:**	***Name:**	***ProviderOne ID #:**	***DOB:**
Address (not required if homeless):		***City, State ZIP:**	
Phone number:		**Email:**	
Member of a federally recognized American Indian/Alaska Native tribe? ☐ Yes ☐ No *If yes, specify which tribe:*		**Veteran**: ☐ Yes ☐ No ***Referring provider:**	

Part A: Complex needs eligibility requirements

Information in this section is required in order to determine eligibility for supportive housing services.

***Health need (must select at least one)**

The client meets one of the following criteria (as determined by a licensed behavioral health agency):

☐ Mental health need where there is a need for improvement, stabilization or prevention of deterioration to functioning resulting from the presence of a mental illness

☐ Diagnosed with a substance use disorder, as determined by meeting a one or higher level on the *American Society of Addiction Medicine Criteria*

☐ Needs assistance with three or more activities of daily living (ADL) or one or more hands-on ADL (as determined by a Comprehensive Assessment and Reporting Evaluation)

☐ The client a homeless individual with a disability, determined by a coordinated entry assessment.

(Individual assessed to have a complex 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]).

***Risk factors (to be approved by a qualified professional; must select at least one risk factor):**

☐ **Chronically homeless:** an individual with a disabling condition who has been homeless for a period of at least one year, **or** an individual with a disabling condition who has had at least four episodes of homelessness, as long as the combined occasions equal at least 12 months.

☐ **Frequent or lengthy institutional contacts (frequent, as in two or more instances in the past 12 months, or lengthy, as in lasting 90 days or more)**

Is the client transitioning out of an institutional setting? ☐Yes ☐No

If yes, select all that apply:

☐ Nursing

☐ Inpatient psychiatric hospital

☐ Inpatient medical hospital

☐ Correctional program or institution

☐ Foster care facility or other youth facility

Note: *Services will not be authorized if the client is currently placed in an institution for mental disease (IMD) or correctional facility until they transition out of the setting.*

Has the client resided within one of the previously listed institutional settings multiple times in the past year?

☐ Yes ☐ No *If yes, number of times:* _____

☐ **Frequent residential care stays (two or more occurrences in the past 12 months)**

Has the client resided within a residential care facility two or more times in the past 12 months?

☐ Yes ☐ No

If yes, select all that apply:

☐ Evaluation and treatment facility

☐ Inpatient substance use treatment facility

☐ Detox center

☐ Adult residential care, assisted living or adult family home (AFH)

☐ **Frequent turnover of in-home caregivers (three or more occurrences in the past 12 months)**

Has the client experienced frequent turnover of in-home caregivers? ☐ Yes ☐ No

Within the last 12 months, has the client used three different in-home caregiver providers? ☐ Yes ☐ No

☐ **PRISM score (1.5 or above)** *(contact the TPA, MCO, BHO, Health Home or HCS case manager to obtain the PRISM risk score)*

Additional details on risk factors:

Part B: Housing assessment

Please fill out to the best of your ability. This information is required but does not impact eligibility.

***Employment status:**

☐ Unemployed

☐ Employed part time

☐ Employed full time

☐ Nonpaid employment activities

☐ Enrolled in training/education program

***Income source:**

☐ Social Security

☐ Pension

☐ Social Security Income

☐ Social Security Disability Income

☐ Temporary Aid for Needy Families

☐ Housing and Essential Needs

☐ Aged, Blind or Disabled

☐ Employment

☐ Other:

***Total income:**
☐ Less than $10,000
☐ $10,000-$14,999
☐ $15,000-$19,999
☐ $20,000-$24,999
☐ $25,000-$29,999
☐ $30,000-$34,999
☐ $35,000 or more

***Housing type:**
☐ Transitional/temporary housing
☐ Permanent housing
☐ Not housed (homeless)

***If homeless, choose type**:
☐ Living in a place not meant for human habitation (e.g., car)
☐ In an emergency shelter
☐ Homeless but admitted to a hospital or other institution for less than 30 days
☐ At imminent risk of losing housing
☐ Evicted or foreclosed within 30 days with no future residence identified
☐ Couch surfing or doubled up
☐ Other:

Strengths
Please fill out to the best of your ability. Information in this section assesses the individual's housing preferences, needs and assets. This information does not impact eligibility.

Identify individual traits that support the client's ability to obtain and maintain housing. Select all that apply.

☐ Motivated to obtain housing
☐ Long-term rental history
☐ Support from family/friends
☐ Paying rent/utilities
☐ Lease compliance
☐ Housekeeping
☐ Money management
☐ Driving/using public transportation
☐ Arranging apartment repairs
☐ Managing/using caregivers
☐ Managing health care needs
☐ Maintaining benefits
☐ Shopping for food and necessities
☐ Taking medication
☐ Filling prescriptions
☐ Hygiene
☐ Paying bills
☐ Getting along with neighbors, landlords, etc.
☐ Meal preparation
☐ Motivated to resolve legal/credit issues
☐ Desire to work or engage in community activities
☐ Other:

Housing preference

Setting:

☐ Urban/downtown ☐ Urban/residential neighborhood ☐ Suburban ☐ Rural/small town

Close to:

☐ Transportation ☐ Shopping ☐ Medical services ☐ Family/friends ☐ Place of worship
☐ Recreation/cultural ☐ Other:

Living space:

☐ Studio ☐ 1 bedroom ☐ 2 bedroom ☐ Onsite laundry ☐ Nonsmoking ☐ Smoking allowed
☐ Pets allowed ☐ Bottom floor/elevator ☐ Accessible unit ☐ Parking

Please describe other relevant housing preferences:

Personal information related to housing placement

Does the client use a wheelchair? ☐ Yes ☐ No

If yes, please list:

Width: _____ Manual or electric: _____

Does the client have a pet? ☐ Yes ☐ No
Does the client have a service animal? ☐ Yes ☐ No
Does the client smoke? ☐ Yes ☐ No
Does the client use medical marijuana? ☐ Yes ☐ No
Has the client served in the U.S. military with a qualified discharge? ☐ Yes ☐ No
Has the client ever been arrested? ☐ Yes ☐ No
If yes, was the client charged and convicted of a crime? ☐ Yes ☐ No
Is the client a registered sex offender or been convicted of manufacturing methamphetamines? ☐ Yes ☐ No (*If yes, no federal subsidies allowable*)

Will anyone else be living with the client? ☐ Yes ☐ No

If yes, select type, and list name and contact information:

☐Family/partner/friend:

☐Live-in aide:

Please describe other relevant personal information related to housing placement:

Housing history

Does the client have any rental history? ☐ Yes ☐ No

Has the client ever received subsidized housing from a public housing authority? ☐ Yes ☐ No

Does the client owe anyone or any public housing authority past-due rent? ☐ Yes ☐ No

Has the client ever been evicted from rental housing? ☐ Yes ☐ No

If yes, please list dates:

Transportation information

Does the client rely on public transportation? ☐ Yes ☐ No

Does the client have a vehicle? ☐ Yes ☐ No

Describe the client's transportation needs:

Housing options to review/explore

Are any of the options below available and appropriate for the individual? ☐ Yes ☐ No

If yes, select all that apply:

Tenant-based rental assistance:

☐ Housing choice

☐ Nonelderly disabled

☐ Veteran's Assistance Supportive Housing

☐ Family Unification Program

☐ HOPWA

☐ Other:

Project-based rental subsidy:

☐ HUD 811

☐ HUD 202

☐ Low-Income Housing Tax Credit

☐ Other:

Continuum of care:

☐ Shelter care

☐ HPRP

☐ Permanent supportive housing

☐ Transitional housing

☐ Other:

Department of Commerce subsidized:

Other HUD or USDA subsidy:

County/city program:

Other:

Documentation available:

☐ Social Security card
☐ Background check results
☐ Proof of income
☐ Documentation of other assets
☐ Birth certificate
☐ Legal resident status
☐ Protective payee

Notes:

Assessment completed by:	**Position/credentials:**	**Date:**
Signature:	***Provider name:**	
Assessment supervised by (if applicable):	**Position/credentials:**	**Date:**
Signature:		
***Enrollee consent for services (print name):** *Please indicate verbal consent in the notes below if signature was not attainable (required if no signature)*		
***Enrollee signature:**		***Date:**
Notes:		