Part I: Referral Source

<table>
<tr><td>Who is Referring this member to CIS?</td><td colspan="3">☐ Self ☐ Family/Friend ☐ Medical Care Provider
☐ Nursing Home Provider ☐ Social Services Provider
☐ Correctional Facility
☐ Other, please specify</td><td>Other Referral Source:</td></tr>
<tr><td colspan="2">Referrer Name:</td><td colspan="2">Agency Name (if applicable):</td><td>Contact Person for Additional Information:</td></tr>
<tr><td>Referral Date:</td><td colspan="2">Contact Phone Number:</td><td>Contact Fax Number:</td><td>Contact E-Mail Address:</td></tr>
</table>

Part II: Member Information

<table>
<tr><td colspan="2">Member First Name</td><td colspan="2">Member Last Name</td><td>Middle Initial</td><td colspan="2">Medicaid ID#</td><td colspan="2">Member Age (Years)</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="9">Current Residential Address:</td></tr>
<tr><td>Street:</td><td colspan="3"></td><td>City and State:</td><td colspan="2"></td><td>Zip Code:</td><td></td></tr>
<tr><td colspan="9">Mailing Address (if different from current address):</td></tr>
<tr><td>Street:</td><td colspan="3"></td><td>City and State:</td><td colspan="2"></td><td>Zip Code:</td><td></td></tr>
<tr><td rowspan="3">Best Contact Phone Information:</td><td>Number</td><td>Can receive texts?</td><td rowspan="3">Email Address:</td><td colspan="2" rowspan="3">Any friends or family who can help reach you?
Yes ☐ No ☐
If yes, please specify:</td><td colspan="3">Contact Name:</td></tr>
<tr><td>1.</td><td>Yes ☐ No ☐</td><td colspan="3">Contact Ph Number:</td></tr>
<tr><td>2.</td><td>Yes ☐ No ☐</td><td colspan="3">Relationship to Member:</td></tr>
<tr><td colspan="2" rowspan="3">If deemed eligible for CIS, anyone the member would like present for the assessment and action planning steps?</td><td rowspan="3">Yes ☐
No ☐
If yes, list:</td><td colspan="3">Name:</td><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Ph Number:</td><td colspan="3">Ph Number:</td></tr>
<tr><td colspan="3">Relationship to Member:</td><td colspan="3">Relationship to Member:</td></tr>
</table>

Part III: PRESUMPTIVE Member Eligibility Information (Subject to Verification and Confirmation)
Please indicate how you believe the member is eligible to receive CIS services.

PART A: HEALTH NEEDS-BASED CRITERIA			
Select		**Criteria (At Least One MUST Apply for Member to be Eligible)**	**Qualifying Diagnoses**
☐		Individual assessed to have a behavioral health need which is defined as one or both of the following criteria:	
	☐	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 serious mental illness; **and/or**	
	☐	Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1 indicating the need for outpatient day treatment for Substance Use Disorder (SUD) treatment.	
☐		Individual assessed to have a 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 the ability to live independently without support).	
PART B: HOUSING CRITERIA			
Select		**Criteria (At Least One MUST Apply for Member to be Eligible)**	**Notes**
☐		**Homeless:**, defined as lacking a fixed, regular, and adequate nighttime residence **(MEMBER WILL QUALIFY IF THEY MEET EITHER CRITIERA BELOW)**	
	☐	Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; **or**	
	☐	Living in a supervised shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels).	
☐		**At risk of homelessness** defined as an individual who will lose primary nighttime residence. **(MEMBER WILL QUALIFY IF THEY MEET ALL CRITERIA BELOW)**	
	☐	There is notification in writing that their residence will be lost within 21 days of the date of application for assistance; **and**	
	☐	No subsequent residence has been identified; **and**	

	☐	The individual 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 or living in a place not meant for human habitation, a safe haven, or an emergency shelter;	
☐		**At risk of homelessness** defined as an individual who will lose primary nighttime residence. **(MEMBER WILL QUALIFY THROUGH EITHER DEFINITION OF INSTITUTIONAL STAYS AND IF THE MEMBER IS IMMINENTLY TRANSITIONING OUT OF THE SETTING)**	
	☐	History of frequent institutional stays (two or more instances in the past 12 months); **or**	
	☐	History of lengthy institutional stays (One or more stays lasting 60 days or more); **and**	
	☐	Member is transitioning out of an institutional setting without a community residence.	
		Select the type of institutional setting the client is currently in (if applicable) ☐ Nursing Facility/Other LTC ☐ Inpatient psychiatric hospital ☐ Inpatient medical hospital ☐ Correctional program/institution	
Referring Party Observations/Concerns (Use the space below to note any specific health concerns or factors the Health Plan should consider in reviewing and prioritizing this referral):			

Part IV: Additional Pertinent Information

Is the member currently a threat to self or others?	Yes ☐ No ☐	If yes, Explain:
Is the member in any immediate danger or did the member disclose experiencing violence or abuse by or fear of another party with whom they are in contact?	Yes ☐ No ☐	If yes, Explain:
Does the member have interpretation needs?	Yes ☐ No ☐	If yes, in which language(s) does the member need interpretation services?

Other Pertinent Information:

I hereby certify that the above statements are true and correct to the best of my knowledge.

Referring Party Name		Date	Signature
Preferred Contact	☐ Phone Number:		☐ Email Address:

Risk Factor Evidence Requirements

Evidence to substantiate how the member meets criteria for CIS must be documented as part of the referral process. Community providers making referrals shall attach any available evidence that corresponds to the eligibility criteria selected in the referral form. The absence of complete documentation should not preclude referral to CIS.

1. Attach any documentation available to substantiate or further describe the member's qualifying health condition(s)
   a. If the member has a Mental Health Need,
      i. Provide any certification of the presence of a Severe and Persistent Mental Illness;
      ii. Provide any other clinical documentation or attestation from a provider of the presence of a Severe Mental Illness;
      iii. If the member is enrolled in CCS, documentation does not need to be provided.
   b. If the member has a Substance Use Need,
      i. Provide clinical documentation or attestation that the substance use disorder meets ASAM level 2.1 or higher;
      ii. Provider verification through ADAD's system, if available.
   c. If the member has a complex Physical Health Need,
      i. Provide clinical documentation or attestation from a provider of the presence of a complex physical health need;

   ii. Provide any other available evidence of routine or excessive use of emergency and inpatient settings;
   iii. If the member is already eligible for LTSS services, documentation does not need to be provided.

2. Attach all documentation available to substantiate a history of homelessness or at risk of homelessness, including but not limited to the following
   a. If the member is already homeless, include as available:
      i. An HMIS record or record from a comparable database;
      ii. A written observation by an outreach worker of the conditions where the individual was living;
      iii. A certification of homelessness;
      iv. A written referral by another housing or service provider;
      v. Where evidence described above cannot be obtained, a certification by the individual seeking assistance, which must be accompanied by the intake worker's documentation of the living situation of the individual seeking assistance and the steps taken to obtain evidence above.[1]

NOTE: Third-party letters must be on agency letterhead, signed and dated. The name and title of the person signing should be indicated.

   b. If the member is at risk of homelessness, based on the criteria selected, the following evidence may be provided:
      i. Eviction letter and proof of current residency at the mailing address from where the member is being evicted
      ii. Evidence individual has a history of frequent or lengthy residence in a facility (Facility Face sheet or Discharge Summary that includes admit, discharge and transfer dates as applicable), and documentation that the individual will be discharged soon.