Community Supports Provider Certification Tool

Instructions:

This Community Supports Provider Certification Tool is intended to ensure the Community Supports provider provides satisfactory evidence of meeting the Community Supports requirements as outlined by the Department of Health Care Services (DHCS) Model of Care to be certified as a Community Supports provider. **Please complete and submit this Community Supports Certification Tool to CalAIM_providers@healthnet.com with the subject line *"Community Supports_<County: Organization Name>_Certification_<Date>"*.** If you have any questions or concerns as you are completing the tool, contact the Plan immediately at the corresponding email below.

Reference Documents for each Community Supports:

- **ECM and Community Supports Standard Provider Terms and Conditions** document provides details on provider expectations: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-ILOS-Standard-Provider-Terms-and-Conditions-05282021.pdf
- **Appendix J (pages 168 - 225) of the CalAIM proposal** provides detailed descriptions of each Community Supports, allowable providers, restrictions and initial eligibility criteria that is subject to change by the Plan: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf

Counties	Email address
Fresno, Kings and Madera	CalAIM_providers@healthnet.com

Health Net*, on behalf of CalViva Health, will review submitted applications and supporting documentation. The Plan will respond to individual Community Supports prospective providers with requests for additional information or clarification regarding areas of the tool that do not satisfy the Community Supports requirement. We are available to work with you to complete this tool and post-submission to ensure certification requirements are satisfied. If the Community Supports requirements are not met, certification will not be granted.

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services.
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23-401/FRM1033650EH01w (5/23)

Community Supports Provider Certification Tool Instructions

Instructions for Tool Completion:
All providers must completely fill out the **Provider Information Section** and **General Provider Section** (Sections 1A-1J). Please **include a narrative response directly in the 3rd column marked Questions for Prospective Providers.** If you need more space, you may also attach a word document. **Please limit your responses to 500 words or less for each section**. For the additional documentation you are submitting with your completed Community Supports certification tool, include the file names of the documents in the 5th column. Utilize the file naming convention described below.

For the **Community Supports-Specific Sections** (Sections 2-15), complete **ONLY** the sections that apply to the Community Supports your organization can offer. Read through the Community Supports description and **include a narrative response directly in the 3rd column marked Questions for Prospective Providers**. If you need more space, you may also attach a word document. **Please limit your responses to 500 words or less for each section**. For the additional documentation you are submitting with your completed Community Supports certification tool, please include the file names of the documents in the 5th column. Use the file naming convention described below.

Instructions for Community Supports Certification Tool and Supporting Document Submission:

1. Email completed electronic Community Supports Certification Tool and additional supporting documentation via zip file(s) to **CalAIM_providers@healthnet.com within two weeks of receipt.**
    a. Use the email **SUBJECT LINE**: "*Community Supports <COUNTY: Organization Name> Certification <Date>"*.
    b. Name the Zip file: "*Community Supports_<COUNTY_Organization Name>_Certification _<Date>"*.
    c. Use sub-folders for each Community Supports (if needed).
    d. Include in your final Zip file the completed electronic Community Supports Certification Tool and all your supporting documents.
        i. The Community Supports Certification Tool should include your narrative responses in the third column and include the names of documents you are submitting as supporting documentation in the fifth column.
        ii. The names of the documents should follow the naming convention described below.
2. Label all individual documents using the **file naming convention** *("<Section #_Doc #_Organization Name_Document Name>_2022<MMDD>")*.
    a. **Section #:** The applicable section number in the Community Supports Certification Tool.
    b. **Doc #:** Number the documents in the order they should be considered.
    c. **Organization Name:** Your organization's abbreviated name or acronym.
    d. **Document Name:** A descriptive name for the document.
    e. **Date of document's creation:** Enter date in the 2022MMDD format.
        i. Example: A list of documents related to Section 2A, which includes an intake form, housing assessment, and organizational chart would be saved in a Zip file using the corresponding naming convention:
            1. *Section 2A_Doc 1_Organization Name_Intake Form_20210903*
            2. *Section 2A_Doc 2_Organization Name_Housing_Assessment_20220903*
            3. *Section 2A_Doc 3_Organization Name_Organizational Chart_20220903*

Reminders:

1. **For all narrative responses, please be clear and concise. Please limit your responses to 500 words or less for each section**
2. Do not include any protected health information (PHI) or personally identifiable information (PII).
3. Avoid acronyms/abbreviations when possible or define acronyms/abbreviations in a list in a supporting document.
4. Use the standard naming convention for all files.

Community Supports Provider Certification Application Section	Page Number	What Community Supports Prospective Providers Should Complete
Provider Information Section	4	All Applicants
1A-1J General Provider Section	5-9	All Applicants
2A-D Housing Transition Navigation Services	10-12	Only applicants who have been invited by the Plan to complete an application to provide this service
3A-D Housing Deposits	13-15	Only applicants who have been invited by the Plan to complete an application to provide this service
4A-D Housing Tenancy and Sustaining Services	16-18	Only applicants who have been invited by the Plan to complete an application to provide this service
5A-D Short-term Post-Hospitalization Housing	19-21	Only applicants who have been invited by the Plan to complete an application to provide this service
6A-D Recuperative Care (Medical Respite)	22-23	Only applicants who have been invited by the Plan to complete an application to provide this service
7A-D Respite Services (for Caregivers)	24-25	Only applicants who have been invited by the Plan to complete an application to provide this service
8A-D Personal Care and Homemaker Services	26-27	Only applicants who have been invited by the Plan to complete an application to provide this service
9A-D Environmental Accessibility Adaptations (Home Modifications)	28-29	Only applicants who have been invited by the Plan to complete an application to provide this service
10A-D Meals/Medically-Tailored Meals/Medically Supportive Foods	30-31	Only applicants who have been invited by the Plan to complete an application to provide this service
11A-D Sobering Centers	32-33	Only applicants who have been invited by the Plan to complete an application to provide this service
12A-D Asthma Remediation	34-35	Only applicants who have been invited by the Plan to complete an application to provide this service
13A-D Day Habilitation Programs	36-39	Only applicants who have been invited by the Plan to complete an application to provide this service
14A-D Nursing Facility Transition/Diversion to Assisted Living Facilities (RCFEs or ARFs)	40-42	Only applicants who have been invited by the Plan to complete an application to provide this service
15A-D Community Transition Services/Nursing Facility Transition to a Home	43-45	Only applicants who have been invited by the Plan to complete an application to provide this service

Provider Information Section: All Prospective Community Supports providers must fill out this section

Community Supports Provider Organization:			
Community Supports Provider Organization Type:			
Tax Identification Number (TIN):			
National Provider Identifier (NPI) (If applicable) **(i.e., Submit type 2 NPI, if applicable. If you have a pending NPI application, indicate here):**			
Completed By:		**Date:**	
Title:			
Phone Number:		**Email Address:**	
Leadership Champion Point of Contact Full Name:		**Email Address:**	
Team Member Point of Contact Full Name:		**Email Address:**	
IT Point of Contact Full Name:		**Email Address:**	

Location and National Provider Identifier (NPI) (i.e., type 2 NPI): ***Please list each location and associated NPI. Add additional rows if needed.***			
Location 1 Address:		**Location 1 NPI:**	
Location 2 Address:		**Location 2 NPI:**	
Location 3 Address:		**Location 3 NPI:**	
Location 4 Address:		**Location 4 NPI:**	
Location 5 Address:		**Location 5 NPI:**	

General Provider Section: All Prospective Community Supports providers must fill out sections 1A-1J

Section	Requirements	Questions for Prospective Providers (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	Required Additional Documentation (Submit what is readily available; gaps can be identified for submission later.)	Name of Attachments (Reference the question related to the attachment.)
Required Area 1A	**General Provider Information** 1. General organization information a. Organization type b. Do you currently have a Managed Care Plan (MCP) contract? If so, for what service(s) and with what MCPs? 2. Services offered 3. Geographic locations served (SPAs) 4. Hours of operations	1. Provide information regarding your organization for all categories to the left (1-4). **Applicant response (attach another page if more space is needed):**	1. Organizational overview and/or mission statement. 2. List of geographic locations served (SPAs) and services offered, with hours of operation.	
Required Area 1B	**Experience Serving Medi-Cal Beneficiaries** Provider is interested in offering Community Supports to full-scope (not Fee-For-Service (FFS)) Medi-Cal managed care population.	1. Are you interested in offering Community Supports to full-scope (not FFS) Medi-Cal managed care population? ☐ Yes or ☐ No 2. Describe your experience serving Medi-Cal beneficiaries and/or other vulnerable populations. Include the estimated percentage of your clients who are Medi-Cal beneficiaries. **(Note: Medi-Cal experience is not required to be considered for Community Supports contracting)** **Applicant response (attach another page if more space is needed):**	1. Client/patient demographic information your organization serves. Reminder: No PII.	

Section	Requirements	Questions for Prospective Providers (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	Required Additional Documentation (Submit what is readily available; gaps can be identified for submission later.)	Name of Attachments (Reference the question related to the attachment.)
Required Area 1C	**Provision of Community Supports Services** ☐ Housing Transition Navigation Services ☐ Housing Deposits ☐ Housing Tenancy and Sustaining ☐ Short-term Post-Hospitalization Housing ☐ Recuperative Care (medical respite) ☐ Respite Services ☐ Day Habilitation Programs ☐ Nursing Facility Transition/Diversion ☐ Community Transition Services/Nursing Facility Transition to Home (launch TBD) ☐ Personal Care and Homemaker Services ☐ Environmental Accessibility Adaptations (Home Modifications) ☐ Meals/Medically Tailored Meals ☐ Sobering Centers ☐ Asthma Remediation	1. Check off each Community Supports your organization **is interested in and ready to provide**. Fill out the below corresponding section(s) 2-15 on how your organization plans to provide each Community Supports. Provide additional documentation or attachments as requested.	N/A	N/A
Required Area 1D	**Outreach and Engagement** The Community Supports provider is responsible for conducting outreach and engagement to assigned members. **The Community Supports provider must be able to complete the following:** 1. Accept member referrals from the MCP for authorized Community Supports, up to Community Supports provider's pre-determined capacity. 2. Conduct outreach to the referred member for authorized Community Supports as soon as possible, includes conducting initial outreach within 24 hours of assignment. 3. Be responsive to incoming calls or other outreach from members, includes maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week.	**For each Community Supports you are interested in providing:** 1. Confirm that your organization can accept member referrals from the MCP for authorized Community Supports services. 2. Describe your current outreach and engagement strategies and how you plan to meet the MCP's outreach and engagement requirements. 3. Describe your referral intake process and how you communicate with the MCP and referred members, to ensure timely outreach and engagement. **Applicant response (attach another page if more space is needed):**	1. Policy/procedure or description of the outreach and engagement process. 2. Workflows detailing referral process and timelines for engagement; including how the organization collects and tracks outreach dates and whether the member was engaged, refused or rejected services. 3. Description of staff roles and responsibilities in outreach and documentation. 4. Description that indicates how the member can reach Community Supports provider (i.e., phone or other).	

Section	Requirements	Questions for Prospective Providers (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	Required Additional Documentation (Submit what is readily available; gaps can be identified for submission later.)	Name of Attachments (Reference the question related to the attachment.)
Required Area 1E	**Enrollment and Member Consent** The Community Supports provider will be responsible for obtaining and documenting the member's voluntary enrollment to participate in Community Supports. **The Community Supports provider must be able to complete the following:** 1. Obtain and document that each assigned member agrees to the receipt of Community Supports. 2. Where required by federal law, ensure that members authorize information sharing with the MCP and all others involved in their care as needed to support them and maximize the benefits of Community Supports. 3. Obtain and document member authorization to communicate electronically with the member and/or family member(s), legal guardian, caretaker, and/or authorized support person(s), if it intends to do so.	**For each Community Supports you are interested in providing:** 1. Describe your current member enrollment or member agreement process for program participation and how your organization documents, stores and shares this information with the MCP. If you do not currently have a process, describe how you plan to meet this requirement. 2. Describe how you obtain and document member authorization related to data sharing and communication. 3. Describe how you obtain and document member authorization to communicate electronically with the member and/or family member(s), legal guardian, caretaker and/or authorized support person(s). **Applicant response (attach another page if more space is needed):**	1. Policy/procedure or description that describes the process for obtaining the member's agreement to voluntary enrollment and how the information is documented and stored. 2. Policy/procedure or description for obtaining the member's authorization for release of information and authorization to communicate electronically with the member and/or family member, etc.	
Required Area 1F	**Care Coordination** The Community Supports provider is responsible for coordinating the member's care with other providers, including ECM provider, primary care physician (PCP), MCP, other Community Supports providers, and others as appropriate. **The Community Supports provider must be able to complete the following:** 1. Coordinate with other providers in the member's care team, including ECM provider as applicable, and the member's MCP; 2. If Community Supports is discontinued for any reason, support transition planning for the member into other programs or services that meet their needs.	**For each Community Supports you are interested in providing:** 1. Describe how you currently coordinate care with other providers in the member's care team. 2. Describe how you communicate and share information with other providers and close the loop on any transition planning and/or care coordination the member may need. 3. If you do not have a current process for care coordination, describe how you plan to meet this requirement and what assistance you may need from the MCP. 4. Describe the existing process for discharging clients from your program(s) and transitioning them to other appropriate services. **Applicant response (attach another page if more space is needed):**	1. Policy/procedure or description that describes how the Community Supports provider will coordinate services with the member's care team (PCP, ECM provider, other Community Supports provider, MCP, etc.) and transition to other services as needed. 2. Description of staff roles and responsibilities in the care coordination process. 3. Policy/procedure or description that describes how Community Supports provider will conduct transition planning for the member if Community Supports was discontinued.	

Section	Requirements	Questions for Prospective Providers (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	Required Additional Documentation (Submit what is readily available; gaps can be identified for submission later.)	Name of Attachments (Reference the question related to the attachment.)
Required Area 1G	**Referral to Community and Support Services:** The Community Supports provider is encouraged to identify additional Community Supports the member may benefit from and send additional request(s) for Community Supports to the MCP for authorization.	**For each Community Supports you are interested in providing:** 1. Describe how you currently identify or assess community and support services needs for the member. 2. Describe how you assist the member in connecting to new resources in the community. How do you follow up with the member to ensure services were rendered (i.e., closed loop referrals)? 3. If applicable, do you use resource platforms for sharing community resources or tracking referrals? 4. If you do not have a process currently in place, describe how you plan to meet this requirement and what assistance you may need from the MCP.	1. Policy/procedure or description that describes the process for identifying resource needs and the corresponding referral process. 2. Policy/procedure or description that describes how appropriate services, benefits and resources are determined for the member, and how they are located and accessed in the community (e.g., internal resource guide, directory of community partners, use of 211, findhelp.com, community health record, etc.). 3. Policy/procedure or description that describes the workflow of how referrals are coordinated with the MCP or other community resource, including how the referral is tracked and confirmation that the service/resource was provided.	
		Applicant response (attach another page if more space is needed):		
Required Area 1H	**Cultural and Linguistically Appropriate and Non-Discrimination Service Requirements:** **The Community Supports provider must be able to complete the following:** 1. Comply with cultural competency and linguistic requirements set by the MCP's annual training requirement. 2. Comply with non-discrimination requirements set by State and Federal law and the Contract with the MCP. 3. Demonstrate a history of serving Medi-Cal members in an equitable, non-discriminatory community-based manner.	1. Describe how your organization provides culturally and linguistically appropriate services. Indicate any relevant staff trainings or services that you offer to meet this requirement. 2. Describe how you provide access to translation or interpreter services, including TTY for hard of hearing, to assist members participating in your services/programs. This may include use of MCP resources. 3. Indicate which languages your services are offered in to meet your member's needs. 4. Describe how you monitor for inequitable care/services and access to care/services, and your process for addressing these inequities. 5. Describe how your organization provides services in an equitable, non-discriminatory manner.	1. Policy/procedure that describes how you ensure that services are culturally and linguistically appropriate for members you serve. (Ensure 6th grade reading level, at least 12 pt. font, etc.) 2. Staff training schedule or topics to maintain culturally competent and non-discriminatory service delivery. 3. Policy/procedure that describes how you access translation or interpreter services. 4. Policy/procedure that describes how your organization meets non-discrimination requirements/standards and/or prioritizes equity.	
		Applicant response (attach another page if more space is needed):		

Section	Requirements	Questions for Prospective Providers (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	Required Additional Documentation (Submit what is readily available; gaps can be identified for submission later.)	Name of Attachments (Reference the question related to the attachment.)
Required Area 1I	**Claims and Invoice Submission:** The Community Supports provider shall record, generate and send a claim to the MCP for Community Supports services rendered in the standard format (837 file) **OR** send an invoice to the MCP in a DHCS-specified format (TBD).	1. Describe your current process for recording, generating and submitting claims or invoices for payment of services rendered. Indicate relevant electronic systems or platforms you currently use. 2. If you do not have a current process, indicate how you plan to submit claims or invoices for the Community Supports you are interested in providing. What assistance do you need from the MCP to develop this process? 3. State which format you intend to use to submit claims for Community Supports services (e.g., 837, CMS 1500, UB04). **Applicant response (attach another page if more space is needed):**	1. Describe process for tracking services and submitting claims and invoices. 2. If applicable, provide screenshot of an electronic health record (EHR) or other compliant electronic system that will be used to capture Community Supports service encounters.	
Required Area 1J	**Data Sharing to Support Community Supports:** 1. File data exchange 2. Reporting 3. Privacy, security, and Health Insurance Portability and Accountability Act (HIPAA) requirements	1. Describe your organization's ability to transfer data and reports with the MCP via a secure file transfer protocol (SFTP) site or other secure data exchange mechanism to support service delivery. 2. Describe what data exchange platforms your organization currently uses. 3. Describe your process for developing reports on Community Supports service delivery for MCPs. 4. Describe how you currently meet privacy/security/HIPAA requirements to provide services and prevent data breeches. 5. If you do not have a current process, describe how you plan to meet this requirement and what assistance you may need from the MCPs. **Applicant response (attach another page if more space is needed):**	1. Attestation of Community Supports provider ability to connect to MCP's SFTP sites and retrieve and submit Community Supports provider files. 2. Policy/procedures or screenshots or workflows on how electronic systems are utilized for service delivery and data sharing. 3. Policy/procedure that describes how service delivery data will be captured and reported to the MCP on a regular basis. Reporting requirements for Community Supports will be defined by DHCS. 4. Policy/procedure that describes how your organization meets privacy/security/HIPAA standards.	

Community Supports-Specific Sections 2-15: Prospective Community Supports providers must fill out the Community Supports-Specific sections that apply to the Community Supports your organization can offer and the Health Plan has invited you submit.

Housing Transition Navigation Services				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
2A	**Community Supports Description** Providers must assist MCP members with obtaining housing and have the ability to provide all of the 15 services listed below. **Indicate which of the following services you currently provide (check all that apply):** ☐ 1. Conduct a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers and identification of housing retention barriers. ☐ 2. Develop an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal. ☐ 3. Search for housing and presenting options. ☐ 4. Assist in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history). ☐ 5. Assist with benefits advocacy, including assistance with obtaining identification and documentation for supplemental security income (SSI) eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.	1. Briefly describe how your organization provides these services. 2. What is your current and anticipated future capacity for Community Supports services or programs you offer? 3. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 4. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with subcontractors to supplement in-house services. 5. If there are any required activities for these Community Supports that you do not currently provide, how do you plan to increase capacity to provide them? 6. Would you need assistance from the MCP, and if so, what specific service(s)/activities? 7. Describe any street-based outreach strategies that you currently use or plan to use for this Community Supports service.	1. Provide program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Provide Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. If available, provide policies and procedures describing existing services/programs and process for establishing eligibility. 4. Description of services and programs for people experiencing homelessness. 5. Share current housing needs assessment template and process. 6. Share an example of de-identified member/patient/client housing support plan with member-generated goals. 7. Share housing search process for members/patients/clients. 8. Share benefits advocacy process and timelines. 9. Policy/procedure on street-based outreach; field safety protocols; any partnerships with local street outreach teams. 10. Describe landlord education and engagement process.	
		Applicant response (attach another page if more space is needed):		

	☐ 6. Identify and secure available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs, etc.) and match available rental subsidy resources to members. ☐ 7. If included in the housing support plan, identify and secure resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. (Note: Actual payment of these housing deposits and move-in expenses is a separate Community Supports service under Housing Deposits). ☐ 8. Assist with requests for reasonable accommodation, if necessary. ☐ 9. Landlord education and engagement. ☐ 10. Ensure that the living environment is safe and ready for move in. ☐ 11. Communicate and advocate on behalf of the client with landlords. ☐ 12. Assist in arranging for and supporting the details of the move. ☐ 13. Establish procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized. (Note: The services associated with the crisis plan are separate Community Supports services under Housing Tenancy and Sustaining Services). ☐ 14. Identify, coordinate, secure or fund non-emergency, non-medical transportation to assist the member's mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day. ☐ 15. Identify, coordinate, environmental modifications to install necessary accommodations for accessibility.			
2B	**Provider Capabilities and Best Practices** • Experience serving people experiencing homelessness. • **Admission, Intake, Assessment:** Experience with conducting a housing needs assessment.	1. How long has your organization been providing this service? 2. Does your organization participate in the coordinated entry system (CES)? If so, how? 3. Does your organization have a Homeless Management Information System (HMIS) read/write account?	1. Provide examples of screening tools used to assess risk and housing need. 2. Provide examples of staff training curriculum. 3. Provide additional evidence that demonstrates excellence in providing this Community Supports service.	

	• **Benefits Advocacy:** Experience with benefits advocacy for members, patients and clients, such as completing SSI eligibility and supporting application/appeals process. • **Case Management/Health Navigation:** Experience providing care coordination to clients, including making appointments, transportation and appropriate programming to increase independence and life skills. • **Housing Service Planning & Navigation:** Experience with developing a housing support plan for members, patients and clients. • Experience with housing search and completion of housing support plan for members, patients and clients. • Experience with resolving tenancy issues for members, patients and clients. • Experience providing accompaniment to appointments. • Have access to Coordinated Entry System (CES) and linkage to local Continuum of Care (CoC).	4. Does your organization use trauma-informed care, and/or harm reduction practices? How do you train staff and implement these practices? 5. Does your organization offer any supportive services to assist with mitigating potential housing search barriers (e.g., transportation, childcare)? If so, which ones? 6. If available, what is your housing placement rate for clients/patients?		
		Applicant response (attach another page if more space is needed):		
2C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
2D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service. 3. Do you currently include peers and/or individuals with experience of homelessness in your service delivery model? If so, describe their role in your service delivery. 4. Provide your criteria for hiring persons with lived experiences.	1. Organizational or department charts. 2. Program descriptions that list staffing structure. 3. Evidence that organization has dedicated housing transition navigation services staff.	
		Applicant response (attach another page if more space is needed):		

Housing Deposits				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
3A	**Community Supports Description** Providers must assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a MCP member to establish a basic household that does not constitute room and board. Providers must have the ability to provide all six of the Housing Deposits services. **Indicate which of the following services you currently provide (check all that apply):** ☐ 1. Security deposits required to obtain a lease on an apartment or home. ☐ 2. Set-up fees/deposits for utilities or service access and utility arrearages. ☐ 3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating and water. ☐ 4. First month and last month's rent as required by landlord for occupancy. ☐ 5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy. ☐ 6. Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services, designed to preserve an individual's health and safety in the home, such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon moving into the home.	1. Briefly describe how your organization provides these services. 2. What is your current and anticipated future capacity for Community Supports services or programs you offer? 3. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 4. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 5. Describe your capacity to provide funding for members, prior to payment reimbursement from the MCP. 6. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide them? 7. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. Provide policies and procedures or description of how eligibility is established for a member requesting housing deposit assistance. 4. Policies and procedures or description of how financial assistance amount is determined and requested. Share template documents if available. 5. Policies and procedures or description of checking if a member is already receiving housing deposits/financial assistance from other programs/resources. 6. Policies and procedures or description of how staff gathers appropriate documentation to support housing deposit expenses. 7. Policies and procedures or description on how to verify that financial assistance is paid in a timely manner. 8. Policies and procedures or description of how verification of financial assistance is being paid to the appropriate party. 9. Policies and procedures or description of landlord engagement on behalf of members. 10. Policies and procedures or description of how financial assistance for each member is being tracked and recorded. Share screen shots and description of utilized databases if applicable. 11. Policies and procedures or description of recouping financial assistance if member does not move into housing and expenses were paid.	

			12. Policies and procedures or description on how provider develops invoices to submit for reimbursement. 13. Policies and procedures or description on how to help members obtain medically necessary adaptive aids and services.	
		Applicant response (attach another page if more space is needed):		
3B	**Provider Capabilities and Best Practices**	1. How long has your organization been providing this service? 2. Describe your capabilities to serve the following: ○ Individuals linked to permanent housing. ○ Individuals lacking funds to pay for initial housing costs. ○ Individuals who have the financial resources to cover month-to-month housing costs. 3. Approximately how long does it take for your organization to provide housing deposits, once approved for the individual member? Indicate how often funds are dispersed, turnaround times, and ability to disperse funds by end of business day if necessary. 4. Do you have bundled contracting or other vendor arrangements to provide furniture and household necessities in a timely and cost-effective way? (optional, not a Housing Deposit service requirement). 5. Does your organization have the ability to connect members to other community resources to help members establish a household (i.e., furniture, clothing, jobs, etc.)? 6. Does your organization have the ability to write third party checks to assist with member's housing deposits, issues like cleaning, etc.?	1. If available, sample pricing description for furniture and household necessities. 2. Provide any additional evidence that demonstrates excellence in providing this Community Supports service. 3. Policies and procedures or description on how financial assistance is paid in a timely manner 4. Policies and procedures or description on how your organization sets the budget for housing deposits program expenses.	
		Applicant response (attach another page if more space is needed):		

3C	**Eligibility Criteria**	1. What type of individuals do you currently provide services to? 2. Do you have specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
3D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service. 3. Provide your criteria for hiring persons with lived experiences.	1. Organizational or department charts. 2. Program descriptions that list staffing structure.	
		Applicant response (attach another page if more space is needed):		

Housing Tenancy and Sustaining Services				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
4A	**Community Supports Description** Providers must offer tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Providers must have the ability to provide all 13 of the services listed below. **Indicate which of the following services you currently provide (check all that apply):** ☐ 1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use and other lease violations. ☐ 2. Education and training on the role, rights and responsibilities of the tenant and landlord. ☐ 3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy. ☐ 4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability. ☐ 5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action, including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit. ☐ 6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized. ☐ 7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. The service can be subcontracted out to retain needed specialized skillset.	1. Briefly describe how your organization provides these services. 2. What is your current and anticipated future capacity for Community Supports services or programs you offer? 3. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 4. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 5. If there are any required activities for this Community Supports that you do not currently provide, how would you plan to increase capacity to provide them? 6. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports. 3. If available, provide policies and procedures document describing the existing services/programs and process for establishing eligibility. 4. Describe services and programs for housing tenancy and sustaining services.	
		Applicant response (attach another page if more space is needed):		

	☐ 8. Assistance with the annual housing recertification process. ☐ 9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. ☐ 10. Continuing assistance with lease compliance, including ongoing support with activities related to household management. ☐ 11. Health and safety visits, including unit habitability inspections. ☐ 12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in). ☐ 13. Providing independent living and life skills, including assistance with and training on budgeting, including financial literacy and connection to community resources.			
4B	**Provider Capabilities and Best Practices** **Housing Service Planning & Navigation:** 1) Experience with developing a housing support plan for members, patients and clients. 2) Experience with housing search and completion of housing support plan for members, patients and clients. 3) Experience with resolving tenancy issues for members, patients and clients, including troubleshooting issues with neighbors.	1. How long has your organization been providing this service? 2. Does your organization participate in the Coordinated Entry System (CES)? If so, how? 3. Does your organization have an HMIS read/write account? 4. Does your organization use trauma-informed care, and/or harm reduction practices? How do you train staff and implement these practices? 5. If available, what is your housing retention rate for clients/patients? 6. For how long do you typically provide these services, after housing? 7. Does your organization have the ability to write third-party checks to assist with the member's housing issues like cleaning, etc.?	1. Provide additional evidence that demonstrates excellence in providing this Community Supports service.	
		Applicant response (attach another page if more space is needed):		

4C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
4D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service. 3. Do you currently include peers and/or individuals with experience of homelessness in your service delivery model? If so, describe their role in your service delivery. 4. Provide your criteria for hiring persons with lived experiences.	1. Organizational or department charts. 2. Program descriptions that list staffing structure. 3. Evidence that organization has dedicated housing tenancy and sustaining services staff.	
		Applicant response (attach another page if more space is needed):		

Short-term Post-Hospitalization Housing				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
5A	**Community Supports Description** Providers must provide MCP members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or chemical dependency and recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care. Providers must have the ability to provide all three of the services listed below. **Indicate which of the following services you currently provide (check all that apply):** ☐1. Ongoing supports necessary for recuperation and recovery, such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports, such as Housing Transition Navigation Services. ☐ 2. Conduct a housing assessment. ☐ 3. Develop an individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-term Post-hospitalization Housing.	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? 2. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 3. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 4. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide it? 5. Would you need assistance from the MCP, and if so, with which specific service(s)/activities? 6. Does your organization have its own facilities or is your organization a contractor/subcontractor that works with a provider that has its own facilities? 7. Would you need assistance from the MCP, and if so, with which specific service(s)/activities? 8. Does your organization have its own facilities or is your organization a contractor/ subcontractor that works with a provider that has its own facilities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. If available, provide policies and procedures document describing the existing services/programs and process for establishing eligibility. 4. Description of services, housing units, and programs to promote healing and linkage to appropriate permanent housing following discharge from short-term post-hospitalization housing. 5. Describe policies/procedures and capabilities for transitioning a member out of short-term post-hospitalization housing. 6. Include description of short-term post-hospitalization housing availability (hours of operation) and provision of personal storage units for medication and personal items.	
		Applicant response (attach another page if more space is needed):		

5B	**Provider Capabilities and Best Practices**	**Examples of specific best practices include:** • Wheelchair access/ADA supports. • Informal connections to permanent supportive housing providers. • Co-located health and/or behavioral health services. 1. How long has your organization been providing this service? 2. Describe your capabilities and experience serving the following: • Individuals experiencing homelessness • Individuals discharging from an inpatient setting • Individuals at risk of readmission due to medical or behavioral health needs • Individuals with mental health and/or substance use disorders 3. Do your providers participate in the Bridge to Medication-Assisted Treatment (MAT) program? 4. Does your organization participate in the Coordinated Entry System (CES)? If so, how? 5. Does your organization have an HMIS read/write account? 6. Does your organization use trauma-informed care, and/or harm reduction practices? How do you train staff and implement these practices? 7. What is your permanent housing placement rate from short-term post-hospitalization housing, if available? 8. What are your "house rules?" What would result in a member being asked to leave the facility? 9. Have any of your policies and protocols changed to be responsive to the current Public Health Emergency? 10. What, if any, onsite social and recreational activities or workshops do you offer onsite to support rehabilitation?	1. Provide staff training curriculum and/or list of recent trainings. 2. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	
		Applicant response (attach another page if more space is needed):		

5C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
5D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service. 3. Provide your criteria for hiring persons with lived experiences.	1. Organizational or department charts. 2. Program descriptions that list staffing structure.	
		Applicant response (attach another page if more space is needed):		

Recuperative Care (Medical Respite)				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
6A	**Community Supports Description** Providers must provide short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. Providers must have the ability to provide all 6 of the services listed below **Indicate which of the following services you currently provide (check all that apply):** ☐ 1. Interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). ☐ 2. Limited or short-term assistance with Instrumental Activities of Daily Living and/or ADLs. ☐ 3. Coordination of transportation to post-discharge appointments. ☐ 4. Connection to any other on-going services an individual may require including mental health and substance use disorder services. ☐ 5. Support in accessing benefits and housing. ☐ 6. Gaining stability with case management relationships and programs.	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? How many beds are available in your recuperative care facility? 2. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 3. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 4. What percentage of your residents are placed into housing, versus returning to homelessness upon discharge from your facility? Include an overview of linkage to housing services including possible barriers to services. 5. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide it? 6. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. If available, provide policies and procedures document describing the existing services/programs and process for establishing eligibility. 4. Description of services, housing units, and programs to promote healing and linkage to appropriate supportive housing following discharge from recuperative care. 5. Describe policies/procedures and capabilities for transitioning a member out of recuperative care. 6. Include description of recuperative care availability (hours of operation) and provision of personal storage units for medication and personal items.	
		Applicant response (attach another page if more space is needed):		

6B	**Provider Capabilities and Best Practices** • Experience providing care coordination and linkage to behavioral health and medical appointments to clients including making appointments, transportation and appropriate programming to increase independence and life skills to prepare for discharge from Recuperative Care facility and transition into next housing placement. **Examples of specific best practices include:** • Wheelchair access/ADA supports. • Informal connections to interim or permanent supportive housing providers. • Linkage to hospice care and/or palliative care. • Co-located health and/or behavioral health services.	1. How long has your organization been providing this service? 2. Does your organization participate in the Coordinated Entry System (CES)? If so, how? 3. Does your organization have an HMIS read/write account? 4. Does your organization use trauma-informed care, and/or harm reduction practices? How do you train staff and implement these practices? 5. What is your housing placement rate from recuperative care? 6. What are your "house rules?" What would result in a member being asked to leave the facility? 7. Have any of your policies and protocols changed to be responsive to the current Public Health Emergency? 8. Do you have COVID+ rooms? 9. What, if any, onsite social and recreational activities or workshops do you offer onsite to support rehabilitation?	1. Share existing Policy & Procedure or describe discharge planning process and required documentation in narrative format for how client is transitioned out of recuperative care and into an appropriate interim housing (IH) or permanent supportive housing (PSH) setting. 2. Outline how the agency provides support to individuals with mental health and/or substance use disorders. 3. If available, share information on linkage to hospice or palliative care services. 4. Provide staff training curriculum and/or list of recent trainings. 5. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	
		Applicant response (attach another page if more space is needed):		
6C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	1. Provide a copy of current referral form and/or exclusions list.	
		Applicant response (attach another page if more space is needed):		
6D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service.	1. Organizational or department charts. 2. Program descriptions that list staffing structure.	
		Applicant Response (attach another page if more space is needed):		

Respite Services (for Caregivers)				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
7A	**Community Supports Description** Providers must provide respite services to caregivers of MCP members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. Respite services can be provided in-home or in an approved out-of-home location. **Indicate which of the following services you currently provide (check all that apply):** ☐ 1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals. ☐ 2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals. ☐ 3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? 2. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 3. Describe any services or activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 4. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide it? 5. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. If available, provide policies and procedures document describing the existing services/programs and process for establishing eligibility. 4. Description of services and programs for people who could benefit from receiving this Community Supports service.	
		Applicant response (attach another page if more space is needed):		
7B	**Provider Capabilities and Best Practices**	1. Describe your provider capabilities and any best practices 2. How long has your organization been providing this service?	1. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	
		Applicant response (attach another page if more space is needed):		

7C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
7D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service.	1. Organizational or department charts. 2. Program descriptions that list staffing structure.	
		Applicant response (attach another page if more space is needed):		

Personal Care and Homemaker Services				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
8A	**Community Supports Description** Personal Care and Homemaker Services are provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. This Community Supports should only be utilized if appropriate and if additional hours/supports are not authorized by in-home supportive service (IHSS). **Indicate which of the following services you currently provide (check all that apply):** ☐ 1. Assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. ☐ 2. Assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. ☐ 3. Housecleaning and laundry. ☐ 4. Accompaniment to medical appointments. ☐ 5. Protective supervision for the mentally impaired.	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? 2. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 3. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 4. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide it? 5. Would you need assistance from the MCP, and if so, with which specific service(s)/activities? **Applicant response (attach another page if more space is needed):**	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc., that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. If available, provide policies and procedures document describing the existing services/programs and process for establishing eligibility.	
8B	**Provider Capabilities and Best Practices**	1. How long has your organization been providing this service? 2. Describe your organization's ability/experience with providing services to: • Individuals requiring supervision and/or assistance with ADLs/IADLs. • Individuals who have applied for or are eligible for In Home Supportive Services (IHSS).	1. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	

		• Individual has a home where services will be delivered; or resides in a stable interim location where they can receive these services. • Individuals experiencing homelessness, or who were recently homeless. 3. How does your organization address potential gaps in service coverage due to staff absence?		
		Applicant response (attach another page if more space is needed):		
8C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
8D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service.	1. Organizational or department charts. 2. Program descriptions that list staffing structure.	
		Applicant response (attach another page if more space is needed):		

Environmental Accessibility Adaptations (Home Modifications)				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of attachments** (Reference the question related to the attachment.)
9A	**Community Supports Description** Providers must make physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable MCP members to function with greater independence in the home, without which the member would require institutionalization. Providers must have the ability to provide all of the services listed below **Indicate which of the examples of home modifications that you currently provide to clients.** **Check all that apply:** ☐ 1. Physical or occupational therapy evaluation and report to evaluate the medical necessity. ☐2. Obtain a minimum of two bids from appropriate providers for the requested service. ☐ 3. Provide home visits to determine the suitability of any requested equipment or service. ☐ 4. Ramps and grab-bars to assist beneficiaries in accessing the home. ☐ 5. Doorway widening for beneficiaries who require a wheelchair. ☐ 6. Stair lifts. ☐ 7. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower). ☐ 8. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary. ☐ 9. Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed). ☐ 10. Other:	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? 2. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 3. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 4. If there are any required activities for this Community Supports service that you do not currently provide, how will you plan to increase capacity to provide it? 5. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Description of services and programs for people who could benefit from receiving this Community Supports service. 2. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 3. If available, provide policies and procedures document describing the existing services/programs and process for establishing eligibility. 4. Please provide sample pricing for modifications.	
		Applicant response (attach another page if more space is needed):		

9B	**Provider Capabilities and Best Practices**	1. How long has your organization been providing this service? 2. Describe any certifications that support provision of this Community Supports service, such as Certified Aging-in-Place Specialist (CAPS). 3. Describe any formal/informal relationships with CA-licensed contractors who can install these types of home modifications (DHCS requirement).	1. Evidence/list of any contractors who have this certification – Certified Aging-in-Place Specialist (CAPS) ○ Certified Aging-in-Place Specialist (CAPS) - NAHB 2. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	
		Applicant response (attach another page if more space is needed):		
9C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
9D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service.	1. Organizational or department charts. 2. Program descriptions that list staffing structure. 3. List of CA registered contractors on staff or partnered with organization.	
		Applicant response (attach another page if more space is needed):		

Meals/Medically Tailored Meals/Medically Supportive Foods				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
10A	**Community Supports Description** Community Supports providers must provide Meals/Medically Tailored Meals (MTM) and/or Medically Supportive Foods for eligible members to meet their unique dietary needs. **Indicate which of the following services you currently provide (check all that apply):** ☐ 1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission. ☐ 2. Medically Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases. ☐ 3. Medically Tailored Meals are tailored to the medical needs of the member by a registered dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes. ☐ 4. Medically supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? 2. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization 3. Describe your current service model and length of service. How will you work with the MCP to determine the member's dietary needs? 4. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 5. If there are any required activities for this Community Supports service that you do not currently provide? If so, how would you plan to increase capacity to provide it? 6. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. Policies and procedures for coordinating meal selection (if available) and delivery with members. 4. Policies and procedures for confirming delivered meals and solutioning for meals not received. 5. If available, provide policies and procedures document describing the existing services/programs and process for establishing eligibility.	
		Applicant response (attach another page if more space is needed):		
10B	**Provider Capabilities and Best Practices**	1. How long has your organization been providing this service? 2. What chronic conditions do your meals currently support? 3. Can your meals accommodate any specific dietary preferences a program enrollee may have, such as no red meats, no dairy, Kosher, puree, etc. If so, please list them. 4. Describe the nutritional standards that your organization uses to inform your services. Provide examples of how you meet specific dietary guidelines for addressing specific chronic conditions, such as congestive heart failure, diabetes, kidney disease, etc.	1. Provide a copy of your organization's nutritional standards. 2. Provide nutritional analysis of medically tailored meals/menus. 3. Provide any additional evidence that demonstrates excellence in providing this Community Supports program.	

		5. Describe how you develop medically tailored meals based on evidence-based nutritional practice guidelines under the supervision of a RD or other certified nutrition professional 6. Describe how you provide culturally and medically appropriate meals for a diverse population. 7. Describe your experience serving clients post-hospital or nursing home discharge who would be most vulnerable to readmission without MTM support. 8. If applicable, describe your experience providing medically tailored groceries and/or healthy food vouchers.		
		Applicant response (attach another page if more space is needed):		
10C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	1. Describe services and programs for clients who meet eligibility for MTM, such as: • Individuals with chronic conditions. • Individuals being discharged from the hospital or SNF who are at a high-risk of hospitalization or nursing facility (NF) placement. • Individuals with extensive care coordination needs.	
		Applicant response (attach another page if more space is needed):		
10D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service. 3. Indicate how many registered dieticians or certified nutrition professionals are on staff and their role in your service delivery. 4. Describe any existing meal delivery reporting practices and any documents made available to the MCP.	1. Organizational or department charts. 2. Program descriptions that list staffing structure. 3. Program report samples noting meal delivery outcomes, or online platform snapshots where MCP may acquire reporting as needed.	
		Applicant response (attach another page if more space is needed):		

Sobering Centers				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
11A	**Community Supports Description** Sobering centers are facilities for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) who would otherwise be transported to hospital emergency departments or jail. The centers provide people, primarily those who are homeless or in unstable living situations, with a safe, supportive environment to become sober. Sobering centers provide a variety of services, including medical triage, lab testing, temporary shelter, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education, counseling and navigation to additional substance use or other necessary health care services, and homeless care support services. Providers are required to engage in the four items listed below. **Indicate which of the following services you currently provide (check all that apply):** ☐ 1. When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged. ☐ 2. The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate. ☐ 3. This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to sobering centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care. ☐ 4. The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including housing first,	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? 2. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 3. Describe your organization's relationships with the jail system. 4. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 5. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide it? 6. Would you need assistance from the MCP, and if so, with which specific service(s)/activities? **Applicant response (attach another page if more space is needed):**	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. If available, provide policies and procedures document describing the existing services/programs and process for establishing eligibility. 4. List of all services provided on site at the sobering center.	

	harm reduction, progressive engagement, motivational interviewing, and trauma informed care.			
11B	**Provider Capabilities and Best Practices**	1. How long has your organization been providing this service? 2. Describe how your organization employs these recommended best practices (according to the American College of Emergency Physicians): ○ Sobering centers should have a housing first model. ○ Utilize harm reduction, progressive engagement, motivational interviewing, and/or trauma informed care effectively. 3. Describe your organization's policy on serving people using substances other than alcohol, or any plans to do so in the future. Describe how your organization handles individuals experiencing a concurrent mental health crisis, 4. Describe how your organization engages members with repeated visits. 5. Describe how your organization provides or conducts triage and/or assessment for physical health conditions.	1. Sample training list or curriculum for staff education. 2. Policies and procedures on serving people who are intoxicated with substances other than alcohol, if applicable. 3. Policies and procedures on redirection to emergency medical services when needed. 4. Provide any additional evidence that demonstrates excellence in providing this Community Supports service. 5. Provide document discharge planning.	
		Applicant response (attach another page if more space is needed):		
11C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
11D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service.	1. Organizational or department charts. 2. Program descriptions that list staffing structure.	
		Applicant response (attach another page if more space is needed):		

Asthma Remediation				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
12A	**Community Supports Description** Providers must provide physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. Providers must have the ability to provide **all of** the services listed below. **Indicate which of the examples of asthma remediation you currently provide to clients.** **Check all that apply:** ☐ Allergen-impermeable mattress and pillow dustcovers. ☐ High-efficiency particulate air (HEPA) filtered vacuums. ☐ Integrated Pest Management (IPM) services. ☐ De-humidifiers. ☐ Air filters. ☐ Other moisture-controlling interventions. ☐ Minor mold removal and remediation services. ☐ Ventilation improvements. ☐ Asthma-friendly cleaning products and supplies. ☐ Other interventions identified to be medically appropriate and cost effective.	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? 2. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 3. Briefly describe how your organization will assess appropriateness of services in collaboration with referring provider. 4. Describe how you conduct a home visit to determine the suitability of any requested remediation(s). Indicate timeframe for completing home visits once member referral is received and identify staff members responsible for completing home visits. 5. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 6. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide it? 7. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. Description of services and programs for people who could benefit from receiving this Community Supports service. Indicate how you provide services for both children and adults.	
		Applicant response (attach another page if more space is needed):		
12B	**Provider Capabilities and Best Practices**	1. How long has your organization been providing this service? 2. Describe how you assess member needs and develop an asthma mitigation/care plan.	1. Sample assessment tool and mitigation/care plan, if available. 2. Describe home visit protocols and assessments to identify appropriate remediation resources.	

		3. Describe how you use the Asthma Control Test to assess member eligibility. 4. Describe any processes for mitigating high emergency department (ED) utilization due to asthma, including communication and sharing of care plans with other providers, such as pharmacists, PCP, etc.	3. Provide samples of member educational materials to support asthma remediation strategies. 4. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	
		Applicant response (attach another page if more space is needed):		
12C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	N/A	
		Applicant response (attach another page if more space is needed):		
12D	**Provider Staffing and Capacity**	1. Describe current staffing structure to deliver Community Supports. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service. 3. Do you currently include community health workers (CHWs) and/or promotoras in your service delivery model? If so, describe their role in your service delivery and indicate current languages available in your CHW program.	1. Organizational or department charts. 2. Program descriptions that list staffing structure. 3. If applicable, describe the CHW's role in the Asthma Remediation program at your organization.	
		Applicant response (attach another page if more space is needed):		

Day Habilitation Programs				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
13A	**Community Supports Description** Providers can provide the program in a member's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. Providers must have the ability to provide all 13 of the services listed below. Indicate **(1)** which of the services your organization currently provides to clients; and **(2)** whether the service is provided in-house by your organization, referred to another provider(s), or subcontracted to/purchased from other provider(s). **Indicate which of the examples of Day Habilitation you currently provide to clients.** **Check all that apply:** ☐ 1. Selecting and moving into a home ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 2. Locating and choosing suitable housemates ☐ In-house ☐ Referral	1. Briefly describe how your organization provides these services. What is your current and anticipated future capacity for Community Supports services or programs you offer? 2. What is your current and anticipated future capacity for Community Supports services or programs you offer? 3. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 4. Briefly describe how your organization will assess appropriateness of services in collaboration with referring provider. 5. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 6. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide them? 7. Would you need assistance from the MCP, and if so, with which specific service(s)/activities? 8. How would your organization coordinate care with other Community Supports providers to avoid duplication of services?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc. that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. Description of services and programs for people who could benefit from receiving this Community Supports service. 4. Copy of sample assessment tool and care plan.	

	☐ Subcontracted/purchased ☐ 3. Locating household furnishings ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 4. Settling disputes with landlords ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 5. Managing personal financial affairs ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 7. Dealing with and responding appropriately to governmental agencies and personnel ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 8. Asserting civil and statutory rights through self-advocacy ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 9. Building and maintaining interpersonal relationships, including a circle of support ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 10. Coordination with Medi-Cal managed care plan to link participant to any Community Supports and/or enhanced care management services for which the client may be eligible	**Applicant response (attach another page if more space is needed):**	

	☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 11. Referral to non-Community Supports housing resources if participant does not meet Community Supports eligibility criteria for Housing Transition/Navigation Services ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 12. Assistance with income and benefits advocacy including general assistance/general relief and SSI if client is not receiving these services through Community Supports eligibility criteria or enhanced care management ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 13. Coordination with Medi-Cal MCP to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through Community Supports or enhanced care management ☐ In-house ☐ Referral ☐ Subcontracted/purchased			
13B	**Provider Capabilities and Best Practices**	1. Describe your provider capabilities and any best practices 2. How long has your organization been providing this service?	1. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	
		Applicant response (attach another page if more space is needed):		

<table>
<tr><td>13C</td><td>Training Requirement

Organization has the capabilities to train staff to offer trainings as part of Day Habilitation Program services:
☐ The use of public transportation
☐ Personal skills development in conflict resolution
☐ Community participation
☐ Developing and maintaining interpersonal relationships
☐ Daily living skills (cooking, cleaning, shopping, money management)
☐ Community resource awareness such as police, fire, or local services to support independence in the community</td><td>1. Briefly describe how your organization has the capabilities to provide these trainings.

Applicant response (attach another page if more space is needed):</td><td>1. Policies, procedures, training materials, sign-in sheets confirming staff participated in training.</td><td></td></tr>
<tr><td>13D</td><td>Eligibility Criteria</td><td>1. What types of individuals do you currently provide services to?
2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?

Applicant response (attach another page if more space is needed):</td><td>1. Policies or program overviews that document eligibility criteria for clients.</td><td></td></tr>
<tr><td>13E</td><td>Provider Staffing & Capacity</td><td>1. Describe current staffing structure to deliver this Community Supports.
2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service.

Applicant response (attach another page if more space is needed):</td><td>1. Organizational or department charts.
2. Program descriptions that list staffing structure.</td><td></td></tr>
</table>

Nursing Facility Transition/Diversion to Assisted Living Facilities (RCFEs or ARFs)				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
14A	**Community Supports Description** Providers are required to assist members with living in the community and/or avoid institutionalization, when possible, with the goal being to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Providers must have the ability to provide all six of the services listed below. Indicate (1) which of the services your organization currently provides to clients; and (2) whether the service is provided in-house by your organization, referred to another provider(s), or subcontracted to/purchased from other provider(s). **Indicate which of the examples of Nursing Facility Trans. / Div. to Assisted Living you currently provide to clients.** **Check all that apply:** ☐ 1. Assessing the participant's housing needs and presenting options ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF ☐ In-house ☐ Referral ☐ Subcontracted/purchased	1. Is your organization a California Community Transitions (CCT)[1] Lead Organization working in this space today? 2. Briefly describe how your organization provides these services. 3. What is your current and anticipated future capacity for Community Supports services or programs you offer? 4. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 5. Briefly describe how your organization will assess appropriateness of services in collaboration with referring provider. 6. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 7. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide them? 8. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc., that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. Description of services and programs for people who could benefit from receiving this Community Supports service.	

[1] For more information on California Community Transitions, refer to: https://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx. CCT Lead Organizations employ transition coordinators who work directly with nursing home residents in LTC to support their transition from institutionalization to the community setting of their choice. It's also referred to in California as MFP – Money Follows the Person. Upon transition to the community, the CCT coordinator will follow the beneficiary for up to a year. This allows the beneficiary to continue to receive supports and services to ensure a safe and successful transition.

	☐ 3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history) ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 4. Communicating with facility administration and coordinating the move ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 5. Establishing procedures and contacts to retain facility housing ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 6. Coordinating with the Medi-Cal plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services ☐ In-house ☐ Referral ☐ Subcontracted/purchased	**Applicant response (attach another page if more space is needed):**		
14B	**Provider Capabilities and Best Practices**	1. Describe your provider capabilities and any best practices 2. How long has your organization been providing this service?	1. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	

		Applicant response (attach another page if more space is needed):		
14C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	1. Policies or program overviews that document eligibility criteria for clients.	
		Applicant response (attach another page if more space is needed):		
14D	**Provider Staffing & Capacity**	1. Describe current staffing structure to deliver this Community Supports. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service.	1. Organizational or department charts. 2. Program descriptions that list staffing structure.	
		Applicant response (attach another page if more space is needed):		

Community Transition Services/Nursing Facility Transition to a Home				
Section	**Requirements**	**Questions for Prospective Providers** (A document can be attached if preferred to answer each question; just reference the question related to the attachment.)	**Required Additional Documentation** (Submit what is readily available; gaps can be identified for submission later.)	**Name of Attachments** (Reference the question related to the attachment.)
15A	**Community Supports Description** Providers must help members to live in the community and avoid further institutionalization. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board. Providers must have the ability to provide all seven services listed below. Indicate (1) which of the services your organization currently provides to clients; and (2) whether the service is provided in-house by your organization, referred to another provider(s), or subcontracted to/purchased from other provider(s). **Check all that apply:** ☐ 1. Assessing the participant's housing needs and presenting options ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history) ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 3. Communicating with landlord, if applicable and coordinating the move ☐ In-house ☐ Referral	1. Is your organization a California Community Transitions (CCT)[2] Lead Organization working in this space today? 2. Briefly describe how your organization provides these services. 3. What is your current and anticipated future capacity for Community Supports services or programs you offer? 4. Based on your current staffing plan and capacity to serve members, describe how you would be able to serve all assigned members, and those not currently connected to your organization. 5. Briefly describe how your organization will assess appropriateness of services in collaboration with referring provider. 6. Describe any activities that you currently subcontract or refer to another provider. Provide specifics on how you work with any subcontractors to supplement in-house services. 7. If there are any required activities for this Community Supports service that you do not currently provide, how would you plan to increase capacity to provide them? 8. Would you need assistance from the MCP, and if so, with which specific service(s)/activities?	1. Program flyers, program descriptions, organizational charts, referral or operational workflows, etc., that indicate how your organization currently provides this service. 2. Organization overview and/or staffing plan for current services/programs that are related to this Community Supports service. 3. Description of services and programs for people who could benefit from receiving this Community Supports service.	

[2] For more information on California Community Transitions, refer to: https://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx. CCT Lead Organizations employ transition coordinators who work directly with nursing home residents in LTC to support their transition from institutionalization to the community setting of their choice. It's also referred to in California as MFP – Money Follows the Person. Upon transition to the community, the CCT coordinator will follow the beneficiary for up to a year. This allows the beneficiary to continue to receive supports and services to ensure a safe and successful transition.

	☐ Subcontracted/purchased ☐ 4. Establishing procedures and contacts to retain housing ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility ☐ In-house ☐ Referral ☐ Subcontracted/purchased ☐ 7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one- time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations ☐ In-house ☐ Referral ☐ Subcontracted/purchased			
		Applicant response (attach another page if more space is needed):		
15B	**Provider Capabilities and Best Practices**	1. Describe your provider capabilities and any best practices 2. How long has your organization been providing this service?	1. Provide any additional evidence that demonstrates excellence in providing this Community Supports service.	

		Applicant response (attach another page if more space is needed):		
15C	**Eligibility Criteria**	1. What types of individuals do you currently provide services to? 2. Do you have any specific focus areas or restrictions on eligibility criteria for this service at your organization?	1. Policies or program overviews that document eligibility criteria for clients.	
		Applicant response (attach another page if more space is needed):		
15D	**Provider Staffing & Capacity**	1. Describe current staffing structure to deliver this Community Supports service. 2. Describe what type of support or capacity-building assistance may be needed from the MCP to launch or expand this service.	1. Organizational or department charts. 2. Program descriptions that list staffing structure.	
		Applicant response (attach another page if more space is needed):		