Referral to Tenancy Support Services (TSS)

Montana Medicaid has reimbursement for Tenancy Support Services (TSS) to eligible members. Prior to referring to TSS, Medicaid enrollment must be confirmed. To submit a referral or an extension request, all required fields (marked with asterisk) in this form must be filled out and submitted via fax (406-513-1923) or email (HACS@mpqhf.org). PLEASE NOTE: This is not a secure email address. If you are emailing documents, please ensure they are being sent securely and HIPAA compliant. Upon receipt of the referral Mountain Pacific will reach out to the member to complete the housing eligibility assessment and, if eligible for TSS, Mountain Pacific will complete a care plan.

Please check the following that the member is requesting (choose one only)*:

- ☐ Initial Request for TSS
- ☐ Extension Request for TSS

Member must have 1 from A and 1 from B (1a or 1b) to be referred to TSS.

(A) Member Health Information

Does the member have any of the below?*

- ☐ Symptoms that suggest the presence of a substance use disorder
- ☐ Symptoms that suggest the presence of a serious mental illness
- ☐ Substance Use Disorder (SUD) Diagnosis
- ☐ Serious Mental Illness (SMI) Diagnosis
- ☐ A need for improvement, stabilization, or prevention of deterioration of functioning resulting from a diagnosed SMI and/or SUD or the symptoms that suggest the presence of a SMI or SUD

(B) Member Housing Status Information

(1a) Is member homeless or at risk of homelessness?*

- ☐ Yes
- ☐ No
- ☐ Unknown
  - If member is NOT currently homeless, was the member previously homeless?
    - ☐ Yes
    - ☐ No
    - ☐ Unknown

(1b) Has the member experienced any of the following within the last 12 months*:

- ☐ A history of multiple stays (more than two) or a history of more than two weeks stay in an institutional setting, group home, assisted living facility, or licensed residential healthcare setting
- ☐ Three or more emergency department visits or hospitalizations
- ☐ History of incarceration (jail, prison, detention center)
- ☐ Loss of housing as a result of behavioral health symptoms

Referral Source Information

Date of Referral:* _____

Referral submitted by* (select one):

- ☐ Member Self Referral
- ☐ Dr.
- ☐ SUD/MH Provider
- ☐ Tenancy Support Services Provider
- ☐ Homeless Shelter
- ☐ Hospital
- ☐ PCP/Clinic
- ☐ MHC
- ☐ FQHC
- ☐ Tribal Health Department
- ☐ Other:_____

Referring Individual Name:* _____

Referring Agency Name:* _____

Referrer Phone Number:* _____

Referrer Email Address:* _____

Is member aware of and requesting referral? ☐ Yes ☐ No

Member Information

First Name:* _____ Last Name:* _____

Medicaid Number:* _____

Preferred Language:* _____

Date of Birth:* _____

Gender:* _____ Preferred Pronouns: _____

Mailing address or location:* _____

If member is moving into new address, please include new address.

_____

Member Primary Phone Number:* _____

Best Time to Contact Member: * _____

Member email address:*_____

If the member is currently homeless, please include member designated contact's information including phone, email, mailing address: Please be sure to include a signed release of information (ROI) from the member for this contact.

Designated Contact Name: _____

Designated Contact Phone Number: _____

Designated Contact Address: _____

Designated Contact Email: _____
Current Living Location:*

- ☐ Interim Housing
- ☐ Other Housing
- ☐ Permanent Supportive Housing
- ☐ Shelter
- ☐ Skilled Nursing Facility/Long Term Care
- ☐ Street
- ☐ Unknown

- ☐ Other_____

Address for current living location:* _____

Is the member matched to a housing program, housing voucher, or other publicly funded housing opportunity?*

- ☐ Yes: Please describe _____
- ☐ No
- ☐ Unknown

Provide Member's Health Management Information Systems (HMIS) I.D. if

available:_____
Please share any additional information on the member's housing status and housing needs:

_____

Signatures:
Signature of Referrer*:_____

Signature of Member (if different)*: _____
By signing this form, I attest that the information is true and reflective of member's current status.

If member is diagnosed with a SMI and SUD, following can be completed in order for the member to avoid completing duplicate assessment.

I, _____ (provider name/credentials), have completed the biopsychosocial assessment of _____ (client) on _____(Date) and attest that the member has a qualifying Serious Mental Illness or Substance Use Disorder. The assessment is on file at _____.

Mental Health Professional Name: _____ Credentials: _____

Signature: _____ Date:_____

By signing this form, I attest that the information is true and reflective of member's current status.