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). A referral can also be made by calling (406)443-0320 or 1-800-219-7035.
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

All fields with an * must be filled out or the referral will not be complete and cannot be processed.

Please check the following that the member is requesting (choose one only)*:	
☐ Initial Request for TSS	☐ Extension Request for TSS

Date of Referral:*

Client/Member Information	
Demographics:	
Name*:	Preferred Name:
Medicaid Number*:	Preferred Language:
Date of Birth*:	Gender*:
Mailing Address or location:	
Address*:	Primary Phone*:
City*:	Email*:
State/Zip*:	
If member is moving to a new address, please include new address below:	
Best time to contact member*:	
If the member does not have an email, phone, or physical address, please include member designated contacts information that, if approved, will be utilized to send the plan and/or contact the member.	
Designated Contact Name:	Designated Contact Phone:
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:	

Required Information:*
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 the 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	
Referral Submitted by:* (select one)	
☐ Member Self-Referral	☐ Primary Care Provider
☐ Substance Use Disorder Provider	☐ Mental Health Center
☐ Mental Health Provider	☐ Health Clinic
☐ Tenancy Support Services Provider	☐ Tribal Health Department
☐ Homeless Shelter	☐ Hospital
☐ Other _____	

Referring Individual Name:*	
Referring Agency Name:*	
Referrer Phone Number:*	
Referrer Email Address:*	

Is member aware of and requesting referral?

- ☐ Yes
- ☐ No

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	

Optional Provider Attestation	
If member is diagnosed with a SMI and/or SUD, the following can be completed in order for the member to avoid completing duplicate assessments	
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 of _____(Diagnosis). 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.	

Print Save Reset