VERMONT

Vermont Medicaid PSH Assistance Program
Provider Manual

Updated: January 2026

Table of Contents

PROVIDER MANUAL PURPOSE

This manual serves as a comprehensive guide for contracted agencies delivering services under the Vermont Medicaid Permanent Supportive Housing Assistance (PSHA) Program. It details the scope of services, standards for service delivery, reimbursement and reporting requirements, eligibility criteria, and coordination expectations with Vermont state case managers and provider agencies.

SECTION I: PROGRAM DESIGN AND OPERATIONS

Program Overview

Permanent Supportive Housing (PSH) is an evidence-based intervention proven to be effective in reducing homelessness, emergency department use, hospitalization, and overall healthcare costs while improving overall health and wellbeing for individuals with complex needs. The Vermont Medicaid Permanent Supportive Housing Assistance (PSHA) Program, authorized by Vermont's Global Commitment to Health 1115 Demonstration Waiver, is intended to support PSH services that help Vermonters with complex health and social needs to successfully transition into and maintain residency in permanent housing. PSHA is also explicitly intended to

align with Vermont's existing PSH models and other housing programs to effectively leverage limited resources and make available an array of high-quality services for Vermonters with complex needs.

Benefits available through the Program are based on health needs and risk-based eligibility criteria and fall into the following three categories:

- **Pre-Tenancy Support Services** – Pre-Tenancy Support Services are a set of services that assist Participants with finding and securing permanent housing.
- **Tenancy Sustaining Services** – Tenancy Sustaining Services are a set of services that support Participants' ability to meet their obligations as tenants and maintain their tenancy.
- **Community Transition Assistance**– Community Transition Assistance aids Participants with funding the one-time services, goods, expenses, and modifications necessary for them to successfully move into housing and establish a basic household.

PSHA leverages a Conflict-Free Case Management approach, described below, to ensure that the PSHA services provided for each Participant are grounded in an independent, "conflict-free," person-centered care plan that addresses the Participant's whole-person needs, as required by federal regulations.

The Vermont Office of Economic Opportunity (OEO) in the Department of Children and Families is responsible for program management and quality assurance. OEO implements Conflict-Free Case Management for PSHA.

OEO contracts with local provider agencies (Providers) to implement PSHA services in their communities.

Conflict-Free Case Management

PSHA is authorized as a Medicaid Home and Community-Based Services (HCBS) program, designed to offer Participants the opportunity to receive services in their own homes or communities, rather than in institutional settings, when possible. Federal regulations for HCBS programs require the development of an independent, "conflict-free," person-centered care plan for each Medicaid Member. This means that the care plan cannot be completed by anyone

affiliated with the organization providing direct services under the same program, nor by anyone related by blood, financially responsible, or legally authorized to make decisions on their behalf.

PSHA uses a Conflict-Free Case Management (CFCM) model to comply with these HCBS requirements. Case managers within OEO (CFCMs) coordinate referrals to PSHA and concentrate on care planning that encompasses the participant's broader "whole person" priorities. The aim of the CFCM is to ensure that PSHA housing services are provided within this context of the "whole person," and that each person's comprehensive needs are addressed by PSHA or in collaboration with other community partners. This enables contracted PSHA agencies to deliver services that focus on identifying and addressing the participants' housing-related needs.

Within this framework, CFCMs are responsible for carrying out the following tasks:

- Coordinating with local Coordinated Entry Lead Agencies to request referrals.
- Verifying Medicaid enrollment, determining eligibility for PSHA services according to established criteria, and authorizing Medicaid services.
- Conducting a whole-person assessment of need with each eligible Participant and collaborating with them to develop a person-centered CFCM Care Plan that incorporates their personal goals and priorities, functional and community support, medical, mental health, and substance use disorder needs.
- Referring eligible Participants to Contracted Providers based on established prioritization criteria and Provider capacity.
- Collaborating flexibly with Providers to ensure that all plans and services within the PSHA Program remain aligned with Participant needs and priorities, even as these evolve.
- Reviewing and authorizing requests for Community Transition Assistance funds, as appropriate and available.
- Reviewing and updating the CFCM Care Plan with the Participant at least annually, when the Participant's needs and circumstances change significantly, or at the request of the Participant.

- Assessing the Participant's progress towards achieving the goals identified in their person-centered CFCM Care Plan, as well as their readiness to transition out of the Program (i.e., to a lower level of care delivery), as appropriate.

The expected caseload size for CFCMs is 50-100 Participants.

Note that CFCM is not intended to and should not replicate any of the services provided by Providers, i.e., Pre-Tenancy Supports, Tenancy Sustaining Services, or Community Transition Assistance. The scope of services for Providers within PSHA is described in *Section II: Standards of Services.*

Eligibility and Prioritization Criteria for Individuals Receiving Services

To be eligible for Vermont Medicaid PSH Assistance services, individuals must be:

- Enrolled in Vermont Medicaid
- Age 18 or older
- Eligible for full Medicaid State Plan benefits

Eligible individuals must also demonstrate at least one of the following health needs **and** meet at least one of the following risk-based criteria:

Health Needs Criteria	Risk-Based Criteria
▪ Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness ▪ Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least an ASAM level 1.0, indicating the need for outpatient Substance-Use Disorder (SUD) treatment	▪ At risk of homelessness, as defined by AHS/HUD ▪ History of homelessness, as defined by AHS Housing Policy ▪ History of frequent or lengthy stays in institutional or residential settings • Frequent is defined as one or more stays in the past 12 months

Health Needs Criteria	Risk-Based Criteria
▪ Assistance with one or more activities of daily living (ADLs), instrumental activities of daily living (IADLs), or other daily life skills resulting from the presence of an acquired brain injury. ▪ Individuals assessed to have a need for assistance, demonstrated by the need for assistance with two or more ADLs; or hands-on assistance with one or more ADL. ▪ Individuals assessed to have a complex physical health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a continuing, progressive, or indefinite physical condition, development, or cognitive disability, or an emotional medical condition. ▪ Individuals assessed to have measurable delays in cognitive development and significant observable and measurable delays in at least two of the following areas of adaptive behavior: communication, social/emotional development, motor development, daily living skills.	• Lengthy is defined as 28 or more consecutive days ▪ History of frequent Emergency Department (ED) visits and/or hospitalizations • Frequent is defined as two or more visits within the past six months or four or more visits within a year ▪ History of involvement with the criminal justice system over the past 12 months ▪ History of frequent moves or loss of housing as a result of mental health or SUD symptoms • Frequent is defined as one or more moves /loss of housing due to mental health or SUD symptoms in the past six months ▪ At serious risk of institutionalization due to the lack of available community supports.

Individuals who are eligible for full State Plan benefits and are enrolled in Choices for Care or one of Vermont's special programs defined in 4.4(c) (i.e. Developmental Disabilities Services, Brain Injury Program, or Mental Health Under 22) are eligible for PSHA. Similarly, participants

may be concurrently enrolled in mental health services through their local Designated Agency (DA). However, these individuals cannot obtain any supports from PSHA that duplicate services they receive elsewhere. Most DAs offer housing supports as part of their Community Support services. If a participant is already receiving this and feels their needs are being met, they would not be able to also receive PSHA. However, if they specifically chose to receive PSHA with a different provider or if the DA is unable to meet the complex service needs related to targeted housing supports, they can be enrolled in both programs. This should be documented in the care plan.

Participants will be prioritized for available PSHA slots based on their priority position for Permanent Supportive Housing (PSH) as determined by each Continuum of Care (CoC). Once interest is verified, the Coordinated Entry Lead Agency will refer individuals to PSHA within OEO in order of their established priority for PSH. Once their PSHA eligibility is confirmed by CFCMs, potential or enrolled Participants will maintain their priority based on the order of referral to PSHA. Prioritization standards for each CoC can be found in the CoC's CE Policies and Procedures. According to current CE PSH prioritization criteria, households prioritized for referral will be experiencing chronically homeless according to the definition established by the Department of Housing and Urban Development (HUD).

If situations arise in which no eligible households within the local Coordinated Entry (CE) system meet the chronic homelessness definition, OEO will work with CE and the Provider to develop an alternate referral protocol for households experiencing literal homelessness. If that list is also exhausted, a referral protocol to allow for households meeting the HUD "at risk of homelessness" definition will be established.

Similarly, when regional flexibility is required to support PSHA in meeting its goal of matching permanent services with housing and rental assistance, OEO may work with CE agencies to implement temporary eligibility and prioritization processes.

Eligibility Criteria and Qualifications for Contracted Providers

The State will select providers through a Request for Proposals process. Selected providers must have experience providing similar services and support. Eligible provider types include, but are not limited to, Health Care for the Homeless Programs, Federally Qualified Health Centers, Designated Preferred Providers for the Division of Substance Use Programs, and Housing and Homelessness Services Providers.

Any agency serving as a Contracted Provider must be able to clearly demonstrate the following experience and expertise:

- Strong track record of helping people remain stably housed, or a clear potential to do so in the future.
- Experience working effectively with both tenants and landlords, including public housing agencies and private market landlords.
- Familiarity with affordable housing programs and processes in Vermont, including housing voucher programs, public housing authorities, and other systems and resources.
- Extensive knowledge of the array of existing services available to support housing sustainability, including experience providing housing search and tenancy support services. Critical skills for these services include housing navigation, service coordination, coaching, and motivational interviewing.
- Commitment to and plan for providing high-quality services to all individuals and families, ensuring everyone feels welcome, well-served, and supported regardless of their race, ethnicity, sexual orientation, gender identity and expression, intellectual or physical ability, English language proficiency or preference, or life experiences.
- Capacity to provide services that are linguistically responsive and trauma-informed and grounded in harm-reduction, person-centered care, and assertive engagement models.
- Capacity to take a flexible approach to service delivery that is responsive to the unique housing sustainability needs of individuals and families.
- Principles grounded in the knowledge that housing is a critical foundation on which health can be improved.
- Experience with and/or commitment to Housing as a Social Driver of Health.
- Capacity to empower tenants, through education, about their rights and responsibilities.
- Capacity to quickly respond to concerns and requests from Participants and/or landlords to resolve problems (including eviction actions) before they become a crisis.

- Participation in the local Continuum of Care or Housing Coalition, or the capacity and willingness to do so upon contracting.

- Strong recordkeeping abilities, or the capacity to quickly develop strong recordkeeping abilities, including documenting service delivery required for monthly Medicaid billing. *See section III: Billing and Reimbursement Guidelines.*

Contracted Providers must enter into a signed Agreement with the Department for Children and Families and must enroll as a Medicaid Provider in Vermont.

SECTION II: Standards for Provider Service Delivery

Service Delivery Approach

All PSHA services must be tailored to the unique needs, strengths, preferences, and priorities of each Participant as identified in an assessment. Participants have the autonomy to select and utilize only those services that align with their individual preferences and priorities as long as housing remains the focal point of services. Providers will be committed to the principle that every person deserves access to safe and affordable housing, free from contingencies, pre-conditions, or judgement-based barriers, recognizing housing as a fundamental human right. Providers will uplift supportive services as a means to maximize housing stability, emphasizing rapport development and participant choice.

Providers are expected to embrace the following best-practices and service models, which have been shown to be effective for individuals who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions:

- **Person-Centered Care** – An approach in which engagement in services is voluntary, customized, and comprehensive, reflecting the individual needs and preferences of people experiencing homelessness. Person-Centered Care is holistic and responsive to individual circumstances, tailoring levels of support to the unique needs and strengths of each Participant.

- **Assertive Engagement** – A person-centered approach that leverages the interpersonal skills and creativity of direct service providers to engage individuals and interest them in subsequent services and supports. Assertive engagement is

useful for individuals who struggle with or reject services requiring proactive engagement. Instead, it places the responsibility on service providers to build connection and relationships persistently and consistently. This approach involves taking multidisciplinary services directly to individuals and providing ongoing support.

- **Trauma-Informed Care** – An approach to service delivery that acknowledges the impact of trauma on people seeking services. Services are designed and delivered to emphasize safety, trustworthiness, client choice, collaboration, and empowerment.
- **Motivational Interviewing** – A person-centered counseling approach that focuses on exploring and resolving ambivalence, centering on motivational processes within the individual to facilitate change.
- **Harm Reduction** – A substance-use intervention framework that focuses on helping people manage substance use and reduce harmful consequences to themselves and others, including preventing evictions. The harm reduction philosophy means individuals do not need to be sober to enter housing and are not evicted solely for failing to maintain sobriety.

Program services must be accessible to and sensitive to the needs of Participants whose primary language is not English. Service delivery must consistently demonstrate linguistic and cultural competence and must strive to honor all individuality, including but not limited to race, religion, ethnicity, sexual orientation, gender identity, and financial status.

Service Definitions

The Medicaid PSHA Program includes three distinct services:

- Pre-Tenancy Support Services
- Tenancy Sustaining Services
- Community Transition Assistance

Each service is described in more detail below. Providers must provide all three services for the Participants referred to them, as appropriate.

Note that PSHA services do **not** include the provision of room and board or the payment of rental costs.

- **Pre-Tenancy Support Services –** Pre-Tenancy Support Services are a set of services that assist Participants with finding and obtaining permanent housing. Pre-Tenancy Support Services may include any of the following:
    - Conducting a Standardized Housing Assessment that identifies the Participant's housing needs and preferences, and any barriers related to finding, moving into, and maintaining housing. (Requirements for Standardized Housing Assessments are detailed in the **Service Planning** section.)
    - Developing an individualized Housing Service Plan with the Participant addressing the barriers, needs, and preferences identified in the housing assessment. (Requirements for Service Plans are detailed in the **Service Planning** section.)
    - Identifying and securing available resources to assist with subsidizing rent.
    - Reducing barriers to housing access, such as creating repayment plans for arrears, referring to Rent-Right classes and financial coaching, making connections to legal services, and practicing self-advocacy and communication with potential landlords.
    - Searching for housing aligned with the Participant's identified preferences and presenting housing options to the Participant.
    - Cultivating and leveraging relationships with local landlords. Presenting information on PSHA service, VSHA's Landlord Relief Program, the state's Weatherization Program, and other benefits of renting to low income or previously homeless households. This includes working with individual landlords after Participants are housed. (Written permission for any outreach to individual landlords or program undertaken explicitly on their behalf).
    - Arranging and joining visits to view available housing units, including scheduling appointments and assisting the Participant to secure transportation, childcare, or other necessary supports.
    - Assisting with housing applications and assembling the documentation required for them to become housed (e.g., Social Security card, prior rental history, disability certification).

- Assisting the Participant with benefits advocacy, including assistance with obtaining identification and documentation for SSI/SSDI eligibility and supporting the SSI/SSDI application process. (Note that such services may be subcontracted to access the specialized skills).
- Coordinating resources to cover expenses such as security deposits, moving costs, and other one-time expenses associated with moving into the housing unit. Funding through Community Transition Assistance should be requested only if no other funds are reasonably available.
- Completing applications for Community Transition Assistance, including securing proper documentation.
- Assisting the Participant with requests for reasonable accommodation, if necessary.
- Ensuring that the living environment is safe and ready for move-in.
- Supporting the details of the move to the housing unit.
- Establishing procedures to support housing retention, including sections of the Service Plan focusing on prevention and early intervention services. (Requirements for Service Plans are detailed in the **Service Planning** section.)
- Communicating and advocating in conjunction with or on behalf of the Participant with landlords.
- Building trusting relationships with Participants, per the principles of Assertive Engagement and Person-Centered Care.

Duration: Service duration may continue until services are no longer needed by the Participant, as documented in their person-centered CFCM Care Plan, contingent on continued Program eligibility.

- **Tenancy Sustaining Services** – Tenancy Sustaining Services support the Participant's ability to meet tenancy obligations and maintain housing. They include the following:
  - Collaborating with the Participant and others involved in their care (with consent and including CFCMs), to establish and maintain connections with community resources addressing core issues that may impact housing stability. Supports may include mental health and substance use disorder providers, primary care

providers and specialist providers, peer support, job training, legal assistance, and more. Efforts may include scheduling and attending appointments, supporting community involvement, and liaising with CFCMs to address emerging needs.

- Address health needs holistically to enhance housing stability, thereby improving overall well-being.
- Reviewing, updating, and modifying Service and Crisis Plans within a month of move-in on a semi-annual and as needed basis thereafter, ensuring they reflect current needs, preferences, and priorities.
- Assisting the Participant to connect with opportunities for socialization, vocation, recreation, and community integration to develop natural supports aiding housing stability.
- Regular home visits to identify and intervene in behaviors jeopardizing housing, such as late rent payments, hoarding, substance use, and other lease violations.
- Assisting in developing independent living and life skills including budgeting, financial literacy and personal finance, housekeeping, grocery shopping, meal preparation, and personal hygiene.
- Educating on tenant and landlord roles, rights, and responsibilities.
- Coaching on developing and maintaining positive relationships with landlords and property managers to foster successful tenancy.
- Resolving disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse actions, including developing a repayment plan or identifying funding in situations in which the Participant owes back rent or payment for damage to the housing unit.
- Linking to community resources to prevent eviction.
- Assisting in pursuing and maintaining public benefits to support housing stability and overall wellbeing, including SSI/SSDI eligibility and enrollment in benefits like 3 Squares, Medicaid, ReachUp, etc. (These services may be subcontracted out for specialized skills.)
- Assisting with annual housing recertification to retain housing subsidies.

- Providing ongoing lease compliance support and household management activities.
- Assisting with reasonable accommodation requests not initially required at move-in.
- Activating the Participant's crisis plan, as appropriate.
- Conducting regular health and safety visits, as aligned with the agency's safety policies.
- Maintaining trusting relationships with Participants, following the principles of Assertive Engagement and Person-Centered Care.

Duration: Service duration may continue until services are no longer needed by the Participant, as documented in their person-centered CFCM Care Plan, contingent on continued Program eligibility.

Both services should include ensuring Participants maintain Medicaid enrollment as eligible. This will include assisting with recertification, checking statuses, and checking Aid Categories as outlined in Section III Medicaid Eligibility, after recertification, income changes, or significant life events.

- **Community Transition Assistance (CTA)**– This assistance provides funding for one-time services, goods, expenses, and modifications necessary to enable the Participant to establish a basic household.

  CTA is available to Participants with CFCMs approval based on an application Providers are expected to complete, including securing proper documentation as part of Pre-Tenancy Support Services or Tenancy Sustaining Services.

  CTA includes the following:

  - Security deposits required for leases.
  - Set-up fees/deposits for utilities or service access and/or utility arrearages (capped at 6 months total).
  - First month coverage of utilities, including but not limited to gas, electricity, heating, water, and in-home connectivity (counted into the 6-month cap).
  - Moving costs.

- Essential household furniture.
- Pest eradication.
- Other services necessary for health and safety may be made available in the future.

CTA must be clearly identified as reasonable and necessary in the Participant's individualized Housing Search Plan and accessed only when other resources are not reasonably available. The Participant must be receiving Pre-Tenancy Support Services or Tenancy Sustaining Services to be eligible for CTA. Apart from Pest Eradication, CTA may only be used when a household is moving into housing, and requests must be received by CFCMs within 60 days of the housing move-in date.

Service Planning

Service planning is a structured, person-centered, and collaborative process used to guide the delivery of supportive services. The process must be individualized and responsive to each Participant's needs, strengths, preferences, and priorities. For PSHA, service planning consists of the following core components:

- **Standardized Housing Assessment**
- **Housing Service Plan** (including engagement, housing search, and housing retention goals as appropriate)
- **Crisis Plan**

Providers may utilize a single integrated planning document or separate documents to fulfill these requirements, provided the format captures the required elements and adheres to the timelines outlined below.

Overview of Service Planning Process

The service planning process **must begin** with a standardized housing assessment. The Provider, in collaboration with the Participant, must then develop an associated action-focused service plan addressing housing access and crisis planning. Once the Participant is housed, the service plan must be updated to include goals related to housing stability, and crisis planning must be revisited to address tenancy-sustaining

needs. Crisis planning may be included within the service plan or maintained as a separate document revisited during times of transition.

All plans should include space to address the full range of domains related to housing access and stability. Service delivery models and best practices should be clearly reflected in all planning documents developed for Participants.

Relationship between Medicaid Billing and Care Planning

Service plan goals form the foundation for Medicaid-billable services and therefore **must be established at the start of a course of service**. If a service plan cannot be completed within the required timeframe, the Provider must document the reasons, the strategies used to address barriers to completion and include a service goal specifically focused on resolving the delay.

Example:

- *Goal:* Enhance engagement
- *Action Steps:* Assertive outreach to tent sites and food shelves; focus on rapport-building; offer transportation to food shelf.

Service plan goals must align with the Care Plan developed by the Conflict-Free Case Manager (CFCM). Medicaid service notes must clearly reference an active goal on the service plan.

Standardized Housing Assessment

This identifies the Participant's housing preferences, priorities, strengths, and barriers related to housing access and tenancy. The assessment should consider all domains that may impact housing outcomes and must serve as the foundation for the development of service plans. Providers may use any assessment format, provided it captures the information needed to address all required Service Plan elements, as outlined below. Assessment questions may include:

- Unique housing needs, preferences, and accommodations
- Household composition

- Income sources and rent payment options
- Strengths, resources, and applicable natural supports
- Documentation needed to obtain housing
- Obstacles to obtaining housing (e.g., eviction history, criminal history, outstanding rent, negative relationships with well-known landlords)
- Barriers to maintaining housing (e.g., substance use disorder, mental health concerns, chronic homelessness, limited income)
- Interest in education, employment, or other meaningful activities
- Access to food, healthcare, transportation, meaningful activities, legal services, benefits, and other supportive services

  Some Housing Assessment questions may mirror those asked by the CFCMs. With Participant consent, CFCMs may share their completed assessment with the Provider to reduce duplication.

Timeline Requirement: Providers are required to complete the standardized housing assessment with the Participant within **30 calendar days** of Participant enrollment in the Provider's program.

Housing Service Plan

This plan outlines a personalized, systematic approach for service delivery and reflects Participant preferences and priorities. It must document goals, key objectives or action steps, and timelines. Service Plans goals must align with goals created in the CFCM Care Plan.

Providers may use any format for the Service Plan, but it must include required elements, as applicable.

Required Elements

- **Housing Access Goals** and action steps for addressing the Participant's known obstacles to becoming housed, including:

- Strategies to locate and secure housing
- Access to means of rent payment, including subsidies, vouchers, SSI/SSDI, or employment as applicable
- Plans to meet unique needs or preferences (e.g., pets, proximity to healthcare or family, health-related accommodations, etc.
- Steps to attain necessary documentation.
- Strategies to address housing barriers (e.g., legal assistance, coaching on discussing history of evictions or convictions, or negative landlord relationships, resolving outstanding rent)
- Supports to participate in the housing search activities (e.g., transportation, childcare)
- One-time purchases or services needed to move into housing and establish a household (e.g., deposits, furnishings)
- Maintenance of Medicaid enrollment

- **Tenancy Sustaining Goals** and action steps addressing responsibilities and supports needed to successfully manage a household and maintain tenancy. These goals can be added to the existing service plan or started on a new document. Goals are multi-dimensional and may address any domain related to housing stability, including:
  - Strengths and resources
  - Strategies to address barriers to stability (e.g., substance use disorder, mental health needs, lease violations, housekeeping, budgeting skills)
  - Understanding expectations of good tenancy as outlined in the lease and through general norms
  - Plans to ensure timely rent and utility payments
  - Participant-driven goals and strategies to achieve them, including coordination with other providers or natural supports, reducing isolation, and increasing meaningful activities

    - Plans to maintain or increase income or benefits (e.g., Medicaid, employment, training, 3SquaresVT, Reach Up, SSI/SSDI)

- Providers may begin developing and implementing some or all housing support objectives before the Participant becomes housed, as appropriate and in accordance with Participant preferences.

Timeline: The Housing Service Plan must be completed, in collaboration with the Participant, within **45 calendar days** of enrollment in the Provider's program. Plans should be updated as needed to support service delivery and at least **every six months** and at least **one month within housing move-in**. Plans must be shared with the OEO CFCM.

Crisis or Risk Reduction Plan

This plan provides a clear, Participant-driven roadmap for responding to risky situations or crises including safety concerns, disengagement, or threats to housing stability. Plans must reflect Participant preferences and identify individuals and agencies involved in providing support. Crisis plans may be standalone documents or integrated into the service plan, but they must include required elements.

Required Elements

- Identification of risks to self (e.g., health, mental health, substance use)
- Identification of strengths and resources
- Participant-directed strategies for addressing risks, including connections to treatment providers, peer supports, and other supports
- If applicable, contingency plans for periods when the Participant is out of the community (e.g., treatment, incarceration) including arrangements for pets, rent, utilities, and unit security
- Coordination plans with support providers, including names and contact information (with Participant consent)
- Information for an emergency contact

- Alternative contact strategies if the Participant cannot be reached
- Once housed, steps to prevent or respond to eviction, including resolving lease issues, avoiding eviction records or negative references, maintaining subsidies, and/or identifying alternative housing

Timeline: Crisis plans can be completed at the same time as other service planning documents but must be completed with the participant **within 90 calendar days** of enrollment, within **one month of housing move-in,** and updated as needed and when significant changes occur. Crisis plans are required in this Medicaid program. They do not need to be submitted to OEO but may be requested at any time and will be reviewed during programmatic monitoring.

	Assessment	Service Plan	Crisis Plan
Timeline for initial completion	Within 30 days of enrollment	Within 45 days of enrollment	Within 90 days of enrollment
Timeline for ongoing updates	(note that an HMIS update is due annually)	Within one month of move-in AND at least every six months	Within one month of move-in AND whenever significant changes occur

Housing service plans must be shared with CFCMs at OEO.

Housing Standards Guidelines

The Vermont Medicaid Permanent Supportive Housing Assistance Program seeks to support Vermonters to secure and maintain permanent, affordable and safe housing.

PSHA prioritizes Participant choice and supports informed decision-making by thoroughly discussing all potential positive and negative consequences associated with housing options. Community Transition Assistance (CTA) funds may **only** be used when a unit is found to be permanent, affordable, and safe, as documented by the Provider.

Recommended minimum housing standard:

- **Lease Agreement** – The Participant must enter into a formal, standard or sponsored, written lease agreement with a term of one year or more with an option to renew or transition to month to month, unless shorter terms are customary in the local area.

- **Housing Quality Standards** – Housing units must comply with all local and Vermont State housing codes at the time of move in.

  If the Participant uses a housing voucher or moves into a unit subsidized through a local, state, or federal program, the subsidy issuer will verify housing standards. If a subsidy is not involved, the Provider must document habitability standards. *See Appendix A – Habitability Checklist.*

- **Affordability** – Housing units should be "affordable" to the greatest extent possible. The standard for "affordability" is that no more than 30% of a household's gross income should be allocated to rent and utilities. In limited circumstances, and due to housing availability constraints, the Participant may pay up to 50% of gross income towards rent and utilities.

More information can be found in *Appendix B – PSHA Housing Standards Guidance.*

Note: The acceptance of rental units that do not meet preferred housing standards may be considered due to the severe housing shortage in the State. This policy is subject to amendment as conditions evolve.

Coordination and Collaboration with Local Entities

Coordination with local entities is crucial to ensure PSHA Participants receive the support needed to secure and maintain housing. Such local entities may include medical providers (including substance use treatment and mental health providers), public health programs, social services, services for older adults, legal service providers, job training programs, community-based organizations, peer supports, the local Continua of Care (CoC),Coordinated Entry System(s) (CE), homeless services agencies, public housing authorities, housing developers, landlords, property managers, and other operators of local rental opportunities and rental subsidies.

Coordination with local CEs, homeless services, public housing authorities, and other operators of local rental subsidies is particularly relevant for Participants requiring rental subsidy support to secure permanent housing. Providers are expected to coordinate and collaborate with Designated Agencies (DAs) and Social Services Agencies (SSAs) to ensure support is complementary clearly defined, and non-duplicative.

Providers should establish and maintain extensive connections with local entities to facilitate resource access for Participants and productive collaboration with others involved with patient care.

Requirements for Successful Coordination and Collaboration

- **Participate in Vermont's Homeless Management Information System (HMIS)**: HMIS records and stores client-level information on the characteristics and service needs of persons experiencing homelessness or unstable housing within a geographic catchment area. HMIS securely enables real-time coordination with participating agencies. Providers must ensure data entry is accurate, timely, and complete. Data reports from the HMIS will align closely with required quarterly and annual reports.
- **Engage with Coordinated Entry Systems:** Participate in the local Continuum of Care's (CoC) Coordinated Entry System and maintain collaborative relationships to ensure effective service delivery.
- **Participate in the annual Point-in-Time Count:** Engage in the PIT count conducted by the local CoC as required by HUD.
- **Collaborate on Discharges from Institutions:** For Participants referred from institutional settings, work with treatment or case management teams to identify suitable housing options upon discharge.
- **Engage in Team Based Care:** Coordinate with Participants and other providers to ensure supportive, collaborative care, as indicated.

Providers should continually assess and improve practices to ensure seamless, responsive service delivery.

Coordination with Conflict-Free Case Management

Providers must actively and routinely coordinate with CFCMs in all aspects of service delivery. At a minimum, Providers will participate in quarterly coordination meetings with CFCMs to discuss Participant progress, barriers, and emerging needs. Enhanced engagement may be required in response to complex needs upon Participant request.

Providers must provide the CFCMs with current and complete service plans and updates.

Providers must notify the CFCMs, in writing, of specific events affecting Participants, as outlined in the table below:

Event Category	Events
Service and Crisis Plans	• When created. • When significant changes are implemented.
Discharge	• Provider is starting to think about needing to discharge a Participant from their services.
Health / Mental Health	• Long term hospitalization. • Entry into a residential treatment program. • New diagnosis of serious medical condition (e.g., cancer, congestive heart failure, etc.). • Pregnancy. • Worsening physical or behavioral health condition (written notification at the discretion of the Provider, based on Provider observation and/or community/partner agency report). • Death.
Justice Involvement	• Incarceration or re-incarceration – expected to be longer th month.
Level of Care	• Participant is assessed as needing a higher level of care than the PSHA program and coordinated services can provide. • Participant is assessed as being ready to transition to a lower level of care (i.e., out of the PSHA program). Identified duplication of services with other providers that can' resolved through coordination.

Participant Service Engagement	• There has been no contact with the Participant for thirty (30) days, and the Participant cannot be located. • Incident of violence by the Participant towards staff members. • Considerable breach of conduct by a Provider towards the Participant such as: Verbal or physical aggression. Exploitation.
Living Situation	• Participant is or is facing eviction. • Move to another housing unit. • Participant is no longer in the unit due to one of the events noted above *(e.g., extended period of hospitalization, move to long-term residential care, incarceration, etc.).*

Many of these situations require submission of a **Critical Incident Report** to OEO, as outlined in the Critical Incident Report policy. Providers may use the one provided or their own form, provided all required elements are included. *See Appendix C – Critical Incident Report policy and sample form.*

Critical Incident Reports are required to be submitted within **two business days** of an event unless it has the potential to include media involvement in which case OEO should be informed right away. Incident Reports are required in the following situations:

- Participant Death or death caused by the participant
- Abuse, Neglect, or Exploitation of the participant by the provider agency
- Serious Criminal Activity / Incarceration that is expected to last for over a month
- Medical Emergency where the participant could have died or suffered permanent impairment without intervention
- Missing Person
- Suicide Attempt
- Significant Aggression of participant towards provider

*these reports do not take the place of any mandated reporting or Duty to Warn.

Providers should work collaboratively with CFCMs to ensure all plans and services remain aligned with Participant's evolving needs and priorities.

Supporting Program Discharges

Contracted Provider Discharges

Discharge Planning is a collaborative process involving the participants and relevant service providers. Participants **must** be informed of discharge criteria upon PSHA enrollment. Providers coordinate with the CFCMs prior to new discharges.

Discharge Criteria – A Participant may be discharged if:

- The Participant voluntarily elects to discontinue services.
- Goals and objectives in the Participant's Housing Support Plan have been met, indicating stability without PSHA support.
- The Participant becomes eligible for and chooses to receive Pre-Tenancy Support or Tenancy Sustaining Services through another program.
- The Participant is no longer eligible for Medicaid.
- The Participant or their household present safety risks for staff.
- The Participant moves out of the Provider's service area.
- There is sustained loss of contact despite consistent, assertive engagement.
    - Outreach attempts should be varied (time of day, type of outreach, locations, contacting other providers), and documented.
- The Participant is incarcerated or institutionalized, and the expected duration exceeds the time allowed for non-engagement as written in Agency policies.
- The Participant has needs that exceed PSHA service capacity, and alternative care is available.

Discharge Processes –Providers must maintain **written policies and procedures** for Program discharges that incorporate the criteria identified above, and processes outlined below:

- Participants will be informed of discharge criteria at the time of enrollment.
- Providers will communicate planned or potential discharges with the CFCMs as soon as possible.
- Provider policies will include a timeline for engagement requirements. If a Participant is not engaging beyond that time period, despite consistent and assertive outreach efforts by the Provider, the Provider must issue a written notice **at least 14 calendar days** prior to the expected date of discharge. This notice should clearly outline expectations and offer multiple options for re-engagement.
- Participants shall receive written notification of PSHA program discharge from the Provider that clearly states the reason(s) for discharge and includes appeal instructions adherent to the Provider's grievance and appeal policy.
- Participants will be provided with written information about local services and resources that may be useful post-discharge.
- Collaborative transition planning will be initiated approximately six to eight weeks prior to planned discharges, when applicable.

OEO Process and Responsibilities for Disenrollment

- When Participant is no longer eligible for PSHA
    - All Participants receive written notification of Medicaid Program disenrollment from OEO that states the reason(s) for their exit and includes appeal instructions to the State of Vermont.
    - Each termination from the program will result in a PSHA Medicaid benefit disenrollment start date effective on the first calendar day of the following month.
- When Participant is still eligible for PSHA
    - CFCMs will ensure that the individual maintains authorization for Medicaid PSHA services until the expiration of their initial 12-month authorization.

- During that authorization period, individuals may contact the Provider or CFCMs to express a desire to re-engage, explain their reason for initial discharge (e.g., non-engagement, temporary move out of county) and present a plan for consistent engagement.
- The Provider or CFCMs will verify that their initial Medicaid authorization has not yet expired. If it has, re-enrollment eligibility is valid **only until two months** after their previous authorization ended. If the request to re-engage occurs outside that two-month period, the individual must wait to be re-prioritized for the program.
- Re-enrollment is contingent upon the availability of space in the Provider's caseload.
    - If the Provider is below their enrollment cap, they can re-enroll the participant and inform OEO.
    - If the Provider is at full capacity, they will inform OEO, and the individual may re-enroll when space becomes available.
    - If a provider needs to exit a Participant because they have moved out of the service area, OEO will not process disenrollment and will explore referral to a different provider.

Staff Qualifications and Training Requirements

Contracted Providers are responsible for assembling a qualified and supervised workforce. Each position within the PSHA program must be supported by a written job description detailing the required credentials, core competencies, supervision structure, and key responsibilities. Supervision must occur at least bi-weekly, and a performance reviews must be completed at least annually.

Direct Service Staff Qualifications

- **Education and Experience:**
    - Bachelor's or associate degree in a relevant field, and/or;
    - At least one year of relevant experience and/or training in supportive housing or independent living services within a social services setting.

- **Inclusion of Lived Experience:** Recruitment of staff who are qualified peer support providers, recovery support specialists, and/or who have lived experience of homelessness, mental health, substance use conditions, or justice involvement is encouraged, so long as all staff meet the requirements above.
- **Staff-to-Participant Ratio:** Providers must maintain a direct service staff-to-participant ratio between 1:9 and 1:14 or 1:17 as written in individual contracts, unless otherwise agreed upon with the PSHA Program Manager at OEO.
- **Onboarding and Annual Staff Training:** All direct service staff must participate in initial and ongoing training.
    - Required topics include (timelines are recommendations):
        - Person-Centered Care (Within one month)
        - Assertive Engagement (Within one month)
        - HIPAA (required per contract, prior to working with PHI)
        - Mandated Reporting of Abuse or Neglect towards vulnerable adults or children (Within one month)
        - HMIS Training: Staff designated as HMIS users must complete HMIS training and certification (Within one month)
        - Trauma-Informed Care (Within three months)
        - Harm Reduction (Within three months)
        - Motivational Interviewing (Within six months)
        - Team-Based Care (request trainings from your community's AHS Field Director and find resources here: Vermont Team Based Care | Agency of Human Services) (Within six months)
        - Internal agency policies and procedures (e.g., safety during home and community visits, documentation, case record maintenance, client confidentiality, participant rights, grievance processes, service termination policies)

- Recommended topics include:
    - Housing First Principles
    - Racial Equity, Class Consciousness, Working with LGBTQIA Individuals, Culturally Responsive Practices
    - Overdose Prevention
    - Tenant Rights, Reasonable Accommodations
    - Mental Health First Aid, Recovery-Focused Cognitive Therapy, or Intentional Peer Support
    - Conversations About Suicide
    - Services for Individuals who are Aging, Living with Developmental Delays, or Experience Substance Use Disorders
    - Secondary Traumatic Stress and Compassion Fatigue

OEO may request that Providers present written job descriptions, staff credentials, and completed trainings at any time.

Clinical Case Consultation: Providers may consider employing or contracting with a clinician to provide clinical case consultation for direct service staff as indicated.

Contracted Provider Policies and Procedures

Providers are required to establish and maintain comprehensive written policies and procedures that ensure the following:

- **Confidential Case Records**
    - Providers must maintain a complete and confidential case record for each PSHA Participant. Case records may vary by format but must comply with current case management documentation standards. Each record should include:
        - Initial and updated Housing Service Plans

        - Crisis Plans
        - Completed Participant Assessments
        - Participant outreach and progress notes
        - Case conference summaries, as appropriate
    - Each active Participant's case record clearly demonstrates compliance with the minimum level of service delivery required for monthly Medicaid billing for each month a Medicaid reimbursement request is submitted.

- **Grievance Process:**
    - Providers must implement a transparent and accessible Grievance Process. Documentation must show that this process was communicated to Participants prior to Program enrollment. Processes should align with the Department of Vermont Health Access (DVHA) processes for appeals, fair hearings, and grievances.

- **Participant Rights and Responsibilities:**
    - Upon program enrollment with providers, all PSHA participants must receive information related to their rights in the program. This should include:
        - Rights and responsibilities
        - Grievance and appeal processes
        - Notice of Privacy Practices (Reviewed at enrollment, posted in any common meeting areas, and made accessible upon request)
        - Engagement expectations
        - Grounds for discharge
    - Providers will maintain documentation demonstrating this information was shared at enrollment.

- **Termination or Denial of Services:**

- Providers must have a written policy specific to PSHA that clearly states the grounds for Termination or Denial of Services as indicated on Pg. 25-26.

- **Privacy and Security Compliance:**
  - Compliance with the latest Federal and State laws governing the privacy and security of all PHI and PII, including case records, is required. Policies and procedures must include provisions for sharing information with collaborating entities.

- **Non-Duplication of Funding / Fiscal Controls:**
  - Providers must ensure that PSHA funding is not duplicated with other State and Federal funding sources and that services billed to Medicaid are not reimbursed through another program.

- **Additional Policies:**
  - Providers must adhere to any other policies outlined in the contract.

OEO may request to review the written policies and procedures at any time to ensure compliance with the above requirements.

SECTION III: BILLING AND REIMBURSEMENT GUIDELINES

Requirement to Enroll as a Vermont Medicaid Provider

In addition to entering a contract with OEO to provide PSHA services, Providers must enroll and remain active as Vermont Medicaid providers in order to submit claims and receive reimbursement for eligible services. In accordance with Section 6401 of the Affordable Care Act of 2010 (ACA), all enrolled and newly enrolling providers will be subject to federal screening requirements.

Gainwell Technologies serves as the fiscal agent for the Vermont Medicaid Program and processes provider enrollment applications. Instructions for Green Mountain Care (VT Medicaid) enrollment & revalidation can be found at http://www.vtmedicaid.com/assets/provEnroll/GrnMtnCareEnrollInst.pdf

Codes required to enroll with Medicaid to provide PSHA services

- **Provider Type:** T47 (FAMILY SUPPORTIVE HOUSING)
- **Service Code:** S55-Permanent Supportive Housing
- **Taxonomy:** 171M00000X - Case Manager/Care Coordinator

For more details, see Appendix D – Medicaid Enrollment Guide

Reimbursement Rates and Minimum Levels of Service Delivery

For more details, refer to Appendix E – PSHA Services and Community Transition Assistance Reimbursement Rates

Distinct reimbursement rates and processes apply to Pre-Tenancy Support Services and Tenancy Sustaining Services, as compared to Community Transition Assistance, as described below. Exhibit A provides a consolidated fee schedule, including billing codes and reimbursement caps.

- **Pre-Tenancy Support Services and Tenancy Sustaining Services**: These services are reimbursed on a "Per Member Per Month" (PMPM) basis. Providers will bill for each participant for the last day of each month, provided the minimum level of service has been met.
    - **Reimbursement Rate:** $667.00 PMPM
    - **Minimum Service Delivery Requirements:**
        - **Pre-Tenancy Support Services:** Two documented, in-person engagements related to developing, updating, or implementing housing search goals on the Service Plan.
        - **Tenancy Sustaining Services:** Two documented, in-person engagements related to developing, updating, or implementing sustainability goals on the Service Plan.

Providers must deliver services at the level of intensity needed to help Participants with their goals regardless of minimum standards. Documentation of service delivery must be maintained and available upon OEO request.

- **Community Transition Assistance (CTA):** Reimbursed for move ins on a cost basis up to the following caps, as funding allows:

Assistance	Cap
Security deposit	Up to $2,000 One Time*
Move-in support, including essential household furniture	Up to $1,000 Lifetime cap
Essential utilities set-up, in order to move into new housing	Total of $1500 ** • Utility deposits and first month • Payment to reinstate utilities • Utility arrears Lifetime cap
Pest Eradication *** Other services TBD	Up to $3,000 Annual cap

* Housing/Security Deposits can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing a second Security Deposit will lead to more successful permanence in housing.

** Utility costs are capped at a total of 6-months of arrears and allowable payments.

*** Costs for Pest Eradication for bedbugs will be approved if the Participant is responsible for the payment. Following Vermont tenant rights, it is the landlord's responsibility for extermination when the dwelling has two or more units infested with bedbugs simultaneously or the unit was infested prior to move in.

CTA must be clearly identified as reasonable and necessary in the Participant's individualized Housing Search Plan and is only accessible when other resources are unavailable. Participants must be receiving Pre-Tenancy Support Services or Tenancy Sustaining Services to qualify.

Except for Pest Eradication, CTA is meant to be used for moving into housing. Applications will be submitted **no later than 60 days** after a housing move-in date.

All pre-approval or reimbursement requests for CTA must include supporting documentation (e.g., invoices, receipts, etc.) Returned security deposits must go to the lessee on all occasions, despite who made the initial payment.

> All Community Transition Assistance applications must be approved and authorized by OEO, prior to Medicaid billing.

For more information, refer to Appendix F – Community Transition Assistance Policies and Appendix G – Community Transition Application.

Participant Medicaid Eligibility

Medicaid PSHA services are only able to be billed for individuals actively enrolled in the Medicaid State Plan which encapsulates Medicaid Managed Care and Traditional Medicaid. Individuals qualify under different Aid Categories. Up to date Aid Category listings can be found here, AidCategoryListing.pdf. As Aid Categories can be changed due to changes in income and resources, particularly after Medicaid renewal, Provider Agencies can verify participants have active enrollment in eligible Aid Categories through their vtmedicaid.com portal. Examples of Aid Categories that do not qualify include VPharm which assists those with Medicare part D coverage to pay for prescriptions or Qualified Medicare Beneficiaries where Medicaid pays for Medicare costs.

Prior Authorization/Re-Authorization

Prior Authorization (PA) is required for PSHA services reimbursement. Prior Authorizations for Pre-Tenancy and Tenancy-Sustaining Services allow billing for up to twelve months, contingent on maintained Medicaid enrollment. Additional authorizations may be granted following an annual re-assessment. Prior Authorizations for CTA are made on a case-by-case basis.

The CFCM team assesses Participant need and issues Prior Authorization. Providers should contact OEO with questions or updates, particularly at least 30 days prior to the re-assessment/re-authorization to share updated case information related to the ongoing need for services.

Claim Submission Format and Frequency

Contracted Providers can submit claims on paper or electronically:

- **Paper Claims:** Complete and submit the CMS 1500 Form for Medicaid Billing.
- **Electronic claims:** This billing mechanism offers faster processing and payment. Providers can apply for a Transaction Services Account for electronic claims submission capabilities. The application and required forms can be found at http://www.vtmedicaid.com/#/hipaaTools.

Claims for Pre-Tenancy Support Services and Tenancy Sustaining Services can be submitted once per month for each Participant with an active Prior Authorization, provided that minimum service delivery requirements are met. Community Transition Assistance claims may be submitted as needed when approved and up to the identified caps. These funds will be reimbursed to the Provider.

While monthly billing is recommended, Medicaid requires that all claims be submitted within six (6) months of the date of service, in accordance with the Timely Filing rule. More information on Timely Filing deadlines can be found here: https://www.vtmedicaid.com/assets/resources/TimelyFilingFAQ.pdf and in section 3.3 of the GeneralBillingFormsManual.pdf. Claims submitted after 6 months may not be remitted.

Information Needed for Claim Submission

Providers need the following information for claim submission:

- **Provider Type** – T47 (FAMILY SUPPORTIVE HOUSING)
- **Specialty** – S55-Permanent Supportive Housing
- **Taxonomy** – 171M00000X- Case Manager/Care Coordinator

- **Diagnosis Code** – The diagnosis code describes the Participant's condition and the reason for services. All providers should use the following code for their PSHA services:

Z59.9 Problems related to housing and economic circumstances, unspecified

(Z codes may be subject to change)

- **Procedure Code** – The procedure code (also known as the CPT Code) identifies the service or good provided to the Participant for which the claim is being submitted.

  Providers should utilize the following procedure codes and modifiers:

  - Pre-Tenancy Support Services – **H0044 U1**

    (H0044 is the code, U1 is the modifier)

  - Tenancy Sustaining Services – **H0044 U2**

  - Community Transition Assistance
    - Security Deposit – **H0043 U4**
    - Move-in Support – **H0043 U1**
    - Essential Utilities – **H0043 U2**
    - Pest Eradication – **H0043 U3**

  Adjust procedure code modifiers for the month following a Participant's move into housing.

- **Place of Service Code** –The place of service code identifies the location of service. Use the following POS code: **99 –** Other Place of Service

- **Claim Amount** – Identifies the dollar amount of the reimbursement:

  - **Pre-Tenancy Support and Tenancy Sustaining Services** - $667.00 PMPM

- **Community Transition Assistance** – The actual dollar amount spent or to be spent, not exceeding caps.

- **Medicaid ID** – The Medicaid ID, provided upon referral, number identifies the Participant who received the service or good for which the claim is being submitted.

Payment for Services

Payments are made by electronic funds transfer (EFT), set up during the Medicaid provider enrollment process.

Special Investigations Unit

Vermont Medicaid only pays for services that are actually provided and medically necessary. Misrepresentation or fraudulent billing is a felony under Vermont law 33VSA Sec. 141(d). This includes:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on a claim as another allowable service
- Falsely diagnosing so that Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, Section 6. https://vtmedicaid.com/#/manuals

Report suspected fraud, waste or abuse to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.

Performance Measures

Providers must submit a quarterly PSHA Performance Measurement Report to OEO, detailing “PSHA Performance Measures”.
Refer to Appendix H – Performance Measures and Reporting Schedule.

Quarter	Reports Required	Dates Due
Q1 July - September	Quarterly HMIS data	October 15
Q2 October – December	Quarterly HMIS data Semi-Annual Narrative	January 15
Q3 January – March	Quarterly HMIS data	April 15
Q4 April - June	Quarterly HMIS data Annual Narrative	July 15

In the event that reports indicate performance below the expectations outlined in Exhibit B, the Provider, in collaboration with OEO, may develop an Action Plan, Training and Technical Assistance Plan, or a Quality Improvement Plan. The plan must be signed by both parties and submitted to the PSHA Program Manager within 30 days. Continued failure to meet requirements may result in a cancellation of the contract. Meeting or exceeding performance goals will be considered for future funding.

Appendix List

A – Sample Habitability Checklist

B – Housing Standards Guidance

C1 – Critical Incident Reporting Policy

C2 – Sample Critical Incident Report Form

D – Medicaid Enrollment Guide and electronic billing set up instructions

D2 – Medicaid Billing Guidance

E - PSHA Services and Community Transition Assistance Reimbursement Rates

F – Community Transition Assistance Policies

G – Community Transition Assistance Application

H – Performance Measures and Reporting Schedule

I – Sample Note Template and Sample Notes

J – Service Provider Staff Training Expectations