

FAQs: Eligibility & Authorizations

Authorizations

1. Does the member need to provide a signature before I can submit a request to authorize services?

No, a signature is not required to submit an initial request for services, but is required for reauthorization to continue services past the first 30 days of service. However, it is best practice to include a member's signature on the submission of the Initial Assessment Tool. Since this may not be practical in all cases, verbal agreement is allowed if the MCO is able to document member interest. In-network providers may also collect and document member signature and submit an authorization request to the MCO over the phone. Please note that if the member is a child, signature is instead required from the member's parent or guardian.

2. I am unable to access eMEVS to search for member eligibility. What should I do next and how do I gain access?

Not all providers have full access to eMEVS at this time. Only providers enrolled in another provider specialty as a Fee-for Service provider currently have full access to eMEVS.

Alternatively, providers can check for member eligibility by using REVS (a phone-based system) or by contacting the MCO provider customer service lines and providing the member's name and date of birth.

3. I want to request services for a child. Is this allowed, and how does this impact my authorization request?

Providers may seek authorization for services for a child as long as their parent or guardians are not eligible for services (e.g., parents are not enrolled in Medicaid). However, please note that unaccompanied children (children under 18 who do not live with a parent or guardian) are not appropriate for Housing Supports, and the provider should call the NJ Child Abuse Hotline (1-877-652-2873) to determine next steps. It is recommended that Tenancy Providers request authorization for the head of the household if they are eligible.

Tenancy services must be authorized for an eligible individual, even though services naturally benefit the entire household.

As a reminder, when completing the Level of Need Assessment, providers should answer questions that reflect the condition of the authorized member (and not of the household), even if the authorized member is a child.

4. How long is the initial authorization period for Pre-Tenancy or Tenancy Sustaining Services? Does the authorization start from the 1st of the month and go to the end of the month?

The initial authorization lasts for 30 rolling calendar days. Service can begin on any day of the month. Please refer to the [provider guidance](#) (Section 7.C) for full details on how the official start date of services is determined.

- Example: If an in-network provider submits an authorization request on 9/15, the initial authorization window would be from 9/15 through 10/14.

5. How long should I expect it to take for my authorization request to be approved by an MCO?

Requests made by in-network Tenancy services providers must be reviewed within 2 business days. If the request is made by an out-of-network provider, the process may take 7 business days. Please note that while these are the standards, approval turnaround times can vary.

6. What are the key differences in the authorization process for Move-in Supports or Residential Modifications and Remediation Services versus requests for Tenancy services?

While processes for Move-in Supports, Residential Modifications and Remediation Services, Tenancy services all begin with the completion and submission of the Initial Assessment Tool, Move-in Supports and Residential Modifications and Remediation Services are not immediately authorized like Tenancy Services.

Move-in Supports and Residential Modifications and Remediation Services instead follow the below two-step authorization process.

- First, after the provider submits the Initial Assessment Tool, the MCO determines if the member meets program eligibility, has a demonstrated need for services, and does not have any program limitations (e.g., already exceeds lifetime caps).
- Second, providers complete a request for information that MCOs review. For Move-in Supports, the request for information documents items such as itemized goods or service lists, including the associated costs. For Residential Modification and Remediation Services, providers will prepare and submit evaluations to the member's MCO.

For Move-In Supports, MCOs will then make an authorization decision to approve the service and total spending amount. For Residential Modifications and Remediation Services, the MCO will select a provider based on the evaluation and then authorize the provider to deliver the service.

Full detail on the authorization processes for these benefits can be found in the [provider guidance](#) (Section 7.E).

7. When is my organization supposed to complete the Housing Stabilization Plan or Level of Need Assessment?

The Housing Stabilization Plan and Level of Need Assessment must be completed during the initial 30-day service window. If the Level of Need Assessment is submitted past the initial 30 days, this could result in authorization delays. As such, it is required to complete both documents in advance of the end of the 30-day authorization ending. Both documents should not be completed prior to the start of services, and submissions are required to receive reauthorization past 30 days. While providers may complete and submit the Housing Stabilization Plan and Level of Need Assessment on the same day as the Initial Assessment Tool, providers should ensure that there is sufficient communication with the member to be able to complete both forms meaningfully.

Please note that providers are not required to submit the Housing Stabilization Plan or Level of Need Assessment at the same time as the Initial Assessment Tool, and that only the Initial Assessment Tool is required for initial authorization.

8. If I am reauthorizing Tenancy services for a member, is the length of the authorization 150 days or 180 days?

If the request is to extend the initial authorization, without a change in level of need, provider, or service type, the extension will be for 150 days so that the total authorization window is 180 days.

If the first 180 days of authorization are complete and the provider is requesting to extend the authorization, the extension would be for 180 days.

9. How does each MCO accept authorization submissions?

Each MCO accepts authorizations slightly differently. See below a recap of how each MCO accepts authorization submissions. Please note that specific contact information can be found in the Initial Assessment Tool and in the provider guidance on Camden Coalition's [website](#).

- Horizon

- *Out-of-network providers*: Accepts mail, email, and fax submissions
- *In-network providers*: All of the above, plus access to Availity

- UHC

- *Out-of-network providers*: Accepts mail, email, and fax submissions
- *In-network providers*: Same as above (portal not yet active)

- Fidelis

- *Out-of-network providers*: Accepts mail, email, and fax submissions
- *In-network providers*: All of the above, plus access to Availity

- Aetna

- *Out-of-network providers*: Accepts mail, email, and fax submissions
- *In-network providers*: All of the above, plus access to Availity

- Wellpoint

- *Out-of-network providers*: Accepts fax submissions and submissions through Availity
- *In-network providers*: Same as above (fax and Availity)

Service Requirements

10. How do I determine the start date of an authorization so that I can determine how long I have to meet the required number of touchpoints with members?

Providers can find the authorization start date and length listed on the authorization form provided by the MCO. If unsure, recommend connecting with the MCO to confirm.

11. Can I be paid for touchpoints that occurred with a member before I received approval from my MCO?

Providers cannot be paid or receive credit for touchpoints if they occur before the authorized start of services, as determined on the authorization form provided by the MCO. Touchpoints that occurred prior to authorization approval may only count if they occurred during the formal authorization window.

12. My member is already receiving Housing Supports from another provider or housing services through a different program. Is this member eligible for Housing Supports through my organization?

The member is not eligible to receive Tenancy services from more than one provider at a time. The [provider guidance](#) (Section 8.C) describes duplicative programs that would deem a member ineligible to receive Housing Supports across all service types.

However, please note that members may receive Tenancy Services, Move-in Supports, and Residential Modifications and Remediation Services at the same time, and each benefit may be rendered by different providers.

13. My member is no longer eligible for Tenancy Services but has an active authorization. What next steps should I take?

If members are no longer eligible for Housing Supports (e.g., no longer meet social risk criteria and are stably housed, moved out of state, etc.) but have an active authorization, providers should report the change in condition to the MCO Housing Specialist. Providers must facilitate a warm handoff with the member's MCO and provide notice to the member within 14 days of service ending. Complete directions are in the [provider guidance](#) (Section 7.F and 7.G).

14. A member is due to receive their security deposit back. My organization paid the security deposit through Move-in Supports, which was reimbursed by the MCO. Am I responsible to return the security deposit to the MCO?

Providers and MCOs are not responsible for recouping security deposits paid for a Housing Supports member after the member moves out of a home. The landlord should return the security deposit to the member, consistent with the rental agreement (i.e., if the member incurred property damage, landlord might keep the security deposit).

HMIS Documentation

15. Am I required to enter touchpoints in HMIS for the initial 30-day authorization period for Tenancy services?

Yes, all touchpoints with the member must be documented in HMIS including during the initial 30-day authorization, unless exceptions apply (e.g., protections in place for members who are survivors of domestic violence). If exceptions do apply (meaning providers are unable to enter member's information in HMIS), providers are still expected to document touchpoints within their agencies local system of record.

16. When the child is the authorized member, how does this impact what I log into HMIS?

If the child in a household is the authorized member for Tenancy Services, providers should list the adult as the head of household in HMIS but use the child's information when documenting touchpoints in the Contact Log.

17. I am unsure about the exact information I am required to input in HMIS when I log touchpoints with a client. What am I required to log?

To comply with HMIS requirements, providers must log the touchpoint in the HMIS Contact Log. Please reference the requirements established in the [provider guidance](#) (Section 8.B). Touchpoints must be documented with all required fields (as indicated in HMIS) unless the member is protected (e.g., domestic violence).

DMAHS highly encourages providers to comprehensively document case notes in HMIS that reflect the touchpoint activity that occurred (e.g., at a similar level of detail as captured in the EHR).

18. Do MCOs have access rights to see HMIS profiles and perform audits?

Yes, MCOs have read-only access rights, can see HMIS profiles, and can perform audits to ensure that touchpoints are being properly documented.