NJ FamilyCare Housing Supports Program:
Program Tool Best Practices

July 8, 2026

Camden Coalition

Housekeeping

- Please drop your name, organization and role into the chat
- Use the Raise Hand function and we will invite you to come off mute during Q&A

Regional Health Hubs (RHHs) play an important role supporting DMAHS in key initiatives such as the NJ FamilyCare Housing Supports Program.

Camden Coalition will:

- Deliver and curate a training series to support program roll-out
- Serve as a "help line" for providers to field/answer questions and troubleshoot issues through the process
- Liaise between the state, MCOs, and providers to support implementation

All RHHs will:

- Promote the program to recruit a robust network of providers within their regions
- Conduct member/community engagement to inform successful roll-out

Camden Coalition

GNHCC
Greater Newark Health Care Coalition

HCPC Health Coalition of Passaic County

TrentonHealthTeam

Disclaimer

The views, opinions and content expressed herein do not necessarily reflect the official position of the state of NJ's Department of Community Affairs or Division of Medical Assistance and Health Services (DMAHS).

Camden Coalition

Agenda

Announcements

Program Tool Best Practices

- General Program Tool Best Practices
- Housing Stabilization Plan deep dive

Question & Answer

Note: we will prioritize questions related to the material presented today.

Announcement

DCA and DMAHS has launched an additional round of provider expansion grants to support providers in building Housing Supports Program capacity

	Grants will support activities such as:
"Start-up" Track: New & early-stage providers	• Developing processes to **enroll and credential** as a provider • Purchasing technology required to **begin serving members** • **Hiring and onboarding** staff
"Expansion" Track: MCO-contracted providers	• Hiring of staff to **increase service delivery to eligible members** • **Training** for staff to bolster **quality of services** for specialty populations • **Purchase of laptops** for case managers, to enable service to more members
Funding will be tied to programmatic milestones	

Grants are intended to help providers build the **operational, technological, and workforce capacity** required to participate and reach their **full potential** in the Housing Supports Program

4 categories of activities will be eligible for funding as part of grant

Technology

- **Technology systems** that enhance providers' operational capacity and improve the efficiency, accuracy, and compliance of program delivery

Development of business or operational practices

- **Programmatic costs:** activities directly tied to delivery and scaling of Housing Supports services, to support providers in adapting and configuring business and operational processes to function in Medicaid
- **Administrative costs:** proportional support for agency-wide expenses (limited to 10% of the total grant award amount)

Workforce development

- **Hiring** of additional staff to support providers' transition into operating as Medicaid providers and serve a larger number of members
- **Training** for staff to adopt new processes and responsibilities associated with delivering Medicaid-funded services

Outreach, education and stakeholder convening

- Activities to **inform NJ FamilyCare members** about the benefit to increase community awareness of the program and its availability, supporting broader member access

NEW JERSEY HUMAN SERVICES

Draft required application materials

Documentation establishing eligibility

- Start-up Track
  - Qualifications of organization to be credentialed with MCOs
  - LOI with 1+ MCOs
  - Documentation of volume of existing housing case management services
  - Outcomes data for existing programs
- Expansion Track
  - Documentation of volume of existing housing case management services
  - HSP success stories and outcomes data
  - Partner feedback
- All Providers
  - Resources listing
  - Commitment to Housing First
  - Commitment to Inclusion & Incorporation of Feedback from PWLEE

Narrative

- Assessment of current organizational experience and capabilities
- Planned use of grant funding, incl.
  - Gaps in current capacity, plan for growth
  - Plan to build technological and operational capabilities
  - Plan to improve quality of service delivery
  - Proposed project budget and workplan

Additional attachments

- Staff resumes
- Job descriptions of positions created via project
- Evidence of being an active user of HMIS or attestation to become a user
- Board Resolution confirming endorsement of participation in HSP
- Other certifications and documents (e.g., IRS Form 99)

NEW JERSEY HUMAN SERVICES

NJ FamilyCare Housing Supports Program Provider Capacity Expansion 2026: Application Timeline

RFP Launch	July 2, 2026
TA Session 1	July 14, 2026 – 10am
TA Session 2	July 23, 2026 – 10am
Application Submission Due in SAGE	July 31, 2026 by 11:59pm
Award Notification Date	On or about September 21, 2026
Grant Term	Anticipated October 1, 2026 – September 30, 2027

All applicants must attend at least one TA session. Registration is required.

Best Practices for completing HSP tools

Brief Summary from Part 1: Auth Timelines

Best practices on Authorization Timeline:

- Submit IAT and LON as soon as possible, and within 5 days of initial touchpoint with member
- IAT submission date = Day 1 of the service period
- A major focus of the initial 30-day service period should be to complete the Housing Stabilization Plan with the member. To ensure thorough completion, aim to submit around Day 23

Auth Timeline Reminders

- MCOs have 7 days to make an auth determination assuming all forms/paperwork are completed with no missing information
- Get permission/green light from MCO if taking advantage of 5-day grace period

Best Practices for All Program Tools

- Understand the purpose of each tool and the timelines at which they need to be submitted
- **Fill every field out completely.** Do not leave fields blank unless the instructions explicitly state that you can
- Complete relevant forms **with the client** to ensure the information you submit accurately represents the member's situation and goals
- Forms that require completed signatures (IAT, LoN and Housing Stabilization Plan) must have either a wet signature or an e-signature (ex: Docusign)
  - Missing signatures are a common cause of delays in the authorization process
- All Program forms (IAT, LoN and Housing Stabilization Plan) include protected health information and need to be completed, stored and transmitted securely
- Build internal workflows to monitor goal and need status, because as these change the LoN and Housing Stabilization Plan need to be updated and/or resubmitted

Initial Assessment Tool

This is the tool used to demonstrate eligibility for HSP. It is submitted as soon as you start working with a client who you believe is eligible.

- Confirm that the client has active Medicaid and is enrolled with an MCO before starting the process (ask the member, check if they have their card, log into eMEVS or call REVS)
- Check for duplicative services (ex: the member or household member is receiving duplicative services OR the member is already engaged in HSP with another provider)
- Complete this tool during your first touchpoint with the member (assuming they have expressed interest in receiving services)
- **You need either a wet or electronic client signature (ex: Docusign) on the IAT**
  - If the IAT is submitted without a signature, MCOs are required to confirm the member is consenting to services. The process of the MCO confirming interest with the member may cause delays to process the authorization. As a result, it is best practice to include a signature on the IAT.
- **To be eligible for this program, members must have both a clinical and social risk factor.**
  - Providers should not seek authorization for members who do not meet the clinical and social risk criteria.
- Make sure you submit the IAT with the MCO's prior authorization form as required

Initial Assessment Tool

B. SOCIAL RISK CRITERIA

Please complete all information in this section

1. Do you/does the member meet any social risk criteria? (check the box(s) below)

- ☐ Currently experiencing homelessness[1]
- ☐ At risk of homelessness[2]
- ☐ At-risk of institutionalization and requiring a new housing arrangement[3]
- ☐ Transitioning from an institution to the community[4]
- ☐ Recently released from correctional facilities[5]

Check at least one social risk factor

C. CLINICAL RISK CRITERIA

Please complete all information in this section

Note: This category is self-reported *or* observed. It does not require clinical diagnosis.

1. Do you/does the member meet any clinical risk criteria? (check the box(s) below)

- ☐ Chronic health condition[6]
- ☐ Mental health condition[7]
- ☐ Substance misuse[8]
- ☐ Pregnancy[9]
- ☐ Complex mental health condition from intellectual or developmental disability[10]
- ☐ Victims of intimate partner violence, domestic violence, or human trafficking[11]
- ☐ Requires assistance with activities of daily living (ADLs) or instrumental ADLs (IADLs)[12] (e.g., needing assistance with activities such as bathing, dressing, eating, using the toilet, cooking)
- ☐ Repeated emergency department or hospital use[13]

Check at least one clinical risk factor

To be eligible for this program, members must have <u>both</u> a clinical and social risk factor.

- Clear definitions of the criteria are found in the appendix of the IAT.
- A common mistake is forgetting to check off both the Social Risk Factor (Section B) and Clinical Risk Factor (Section C). Remember to select **at least one box in each section** or the MCO will deem the member ineligible.
- **Providers should not submit IATs for members who do not meet this criteria.**

Level of Needs Assessment

This tool determines whether your client is high or low need, determining the appropriate billing rate and number of touchpoints required each month.

- The Level of Needs assessment needs to be submitted only for Pre-tenancy and Tenancy Sustaining Services (not Move-in Supports or Mods/Remediations)
- Best practice is to submit at the same time as the IAT because it gives you the opportunity to receive initial authorization for both delivering services and billing amount
- Technically can be submitted anytime within the initial 30-day service period
- If filling out for a child, all questions should reflect the status of the child, not any of the other household members
  - Ex: Employment status and substance misuse challenges should reflect the child
- This form must be signed by the case manager who completed the assessment.

Housing Stabilization Plan

The Housing Stabilization Plan is used to capture goals, action plans, and progress toward the goals and actions.

- The HSP needs to be submitted only for Pre-tenancy and Tenancy Sustaining Services (not Move-in Supports or Mods/Remediations)
- The HSP must be submitted:
  - Within the first 30-day billing period to facilitate authorization for the next 150-day service period
  - Anytime a meaningful change occurs for the member (ex: finds or loses housing; switching from one service to another; moving LON categories)
  - When looking for reauthorization for the next 180-day billing period
- The HSP must be submitted within the first 30-day billing period. An MCO can request clarification or additional detail if it is not filled out thoroughly.
- Best practice is to ensure you have a thorough and specific plan that you develop in partnership with the client.

Best Practice Call-Out:
Although it may feel efficient to submit the HSP as quickly as possible, MCOs are looking for an adequate level of detail on this form. As a result, submissions early in the initial 30-day period typically increase the likelihood of being asked for more information when approaching re-authorization.

Completing the Housing Stabilization Plan

The Spirit of the Housing Stabilization Plan

The Housing Stabilization Plan is not meant to be a box-checking activity or feel transactional, but a real tool to serve the member.

- Serves as a tool for **meaningful conversation** about the member's goals for their life and well-being
- Opportunity to reinforce and orient the member to the **goals and components of the Housing Supports Program**
- Make sure the case worker and member stay on **the same page**
- Organize long-term and potentially daunting goals into **realistic action steps**
- Acknowledge the **interconnectedness of drivers** like housing, health and financial stability
  - Brainstorm and mobilize other supports and resources outside of the provider agency's scope (ex: leveraging MCO programming, clinical services, connecting to additional benefits)
- **Track progress** to keep provider on track, and keep member motivated and engaged
- **Justify** the use of Medicaid dollars by showing how your work supports the goals and purpose of the program, specifically by connecting actions to **align with the Services Dictionary**
- **Tell the story** of the services delivered to the member so that any potential auditor can clearly see the "back up" for submitted and paid claims

Best Practice Call-outs
The more thoughtfully and thoroughly you are able to complete and maintain this plan, the more likely you are to **build trust and engagement with your client.**

And the more likely you are to **avoid push-back, denials and delays from MCOs.**

This doesn't only translate into **higher quality services**, but a more **financially viable program** for your agency.

Housing Stabilization Plan

Completeness of Submission

- There are four major sections to the plan:
  - **Overall goal for housing**
  - **Housing**
  - **Income or expenses**
  - **Health**
- **For the HSP to be considered "complete"**
  - The overall housing goal narrative must be complete – this is a required field
  - Each section must have at least one goal and one corresponding action
    - There should be no blank columns or missing fields
  - Both client and provider signature with dates are required
  - If submitting for re-authorization, you should be able to show progress demonstrated in the notes section, or completion for at least one action

The SMART Goal Framework

		Not SMART	SMART
Specific	Is the goal specific to me and my life? Does it connote a specific vision of success?	**Get in better shape**	**Long-term goal:** Achieve a level of fitness that allows me to participate in my family's annual tradition of running the 5K Turkey Trot on Thanksgiving. **Intermediate Goals:** • Run at least two times a week starting in June. • By the end of September, be able to run two miles without stopping. • Run a practice 5K in November.
Measurable	Will I know whether or not I've met the goal?		
Attainable	Is it realistic for me to meet the goal?		
Relevant	Are my intermediate goals "in scope" and related to my vision for success?		
Timebound	Is there a timeline for achieving this goal?		

Overall goal for housing: Use this section of the HSP to understand the client's goals for their broader wellbeing, and connect it to their housing, health and income status.

What is your overall goal for housing? (Required field, please limit to couple of sentences)

Best Practice Call-out:

Before you even start this Plan, discuss the Housing Supports Program with the client so they understand what's in and out of scope (ex: does not pay rent; focus on ensuring member has the tools they need to find and keep housing; connection to physical and mental health, etc.).

You can use your knowledge of the Services Dictionary as a guide for this conversation.

This can prevent a challenging dynamic, where for example, the client states all they need is cash assistance to pay their rent.

Overall goal for housing: Use this section of the HSP to understand the client's goals for their broader wellbeing, and connect it to their housing, health and income status.

Client states: *I want my daughter to know I am safe and healthy, and that I can live independently. She works full time and has a family. She lives a couple of hours away. When I get admitted to the hospital, she feels like she needs to be with me, and being a burden to her makes me depressed. Getting admitted to the hospital also gets in the way of my recovery. When I drink, I struggle to stay on top of rent and my bills, and I could lose my housing and my voucher.*

When I see my daughter and her family, I want it to be about spending time together, not just her helping to manage my medications and the headaches of going in and out of the hospital.

Best Practice Call-outs:

The Housing Stabilization Plan should be built with the client and written from their perspective, not from the case manager's point of view.

The "Overall Goal" section is not a throwaway! It is where you will **use motivational interviewing** to have a robust conversation and anchor the plan to the client's priorities.

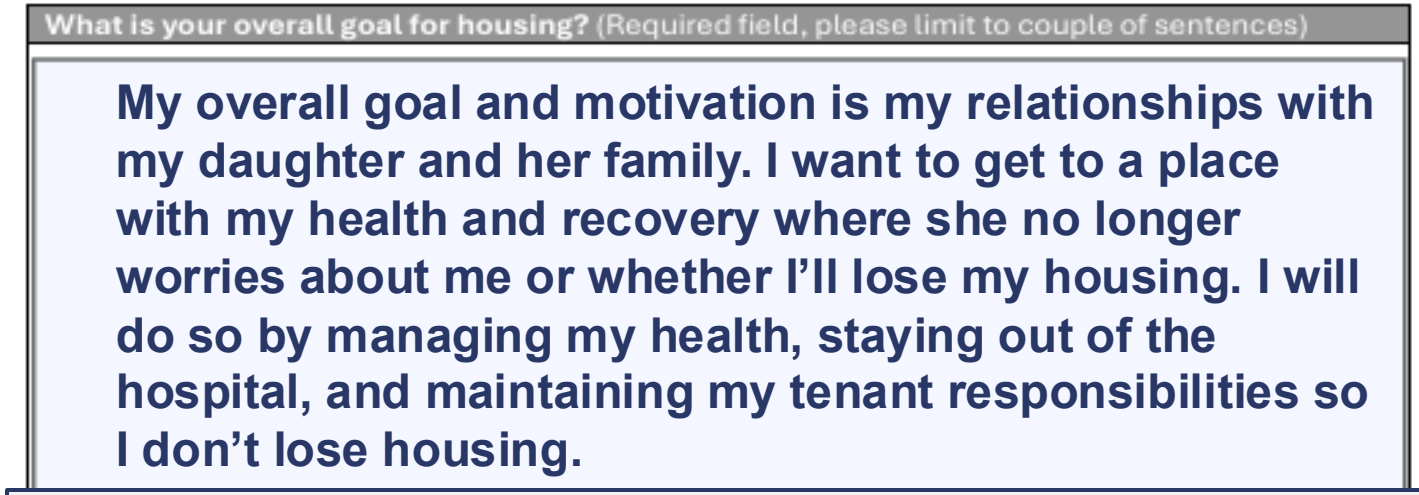
As a case manager, you may have input, guidance and coaching related to what the client needs to do to meet their goals, and you can dynamically provide that input as you build the plan.

Overall Goal for Housing:

Use this section of the HSP to understand the client's goals for their broader wellbeing, and connect it to their housing, health and income status.

Client states: *I want my daughter to know I am safe and healthy, and that I can live independently. She works full time and has a family. She lives a couple of hours away. When I get admitted to the hospital, she feels like she needs to be with me, and being a burden to her makes me depressed. Getting admitted to the hospital also gets in the way of my recovery. When I drink, I struggle to stay on top of rent and my bills, and I could lose my housing and my voucher.*

When I see my daughter and her family, I just want to enjoy them, not have to worry about my health.



Best Practice Call-outs:

Your job as case manager is to help capture the client's goals for their life **from their perspective** and in words that resonate with them **and** translate into the goals and framework of the Housing Supports Program.

At the end of the process of writing this plan, you'll **share a copy with your client.** This holds you accountable to supporting their goals, and holds them accountable for moving the agreed upon actions forward.

Eventually, as you document progress, the plan will also serve as a mechanism to hold MCOs accountable for authorizing and reimbursing services in alignment with HSP guidance.

Goal Setting

3

i. **Housing search/stabilization and retention** *(Please complete all information in this section)*

What are your next steps for obtaining housing or immediate stabilization where you are living? Please include any relevant actions from individuals across the household.

4

ii. **Income/expenses/other resources** *(Please complete all information in this section)*

What is your overall monthly income goal? Please enter a dollar amount. Please enter both your individual goal and the *total* goal of the entire household (individual goal may be $0 if other household members are expected to earn income)

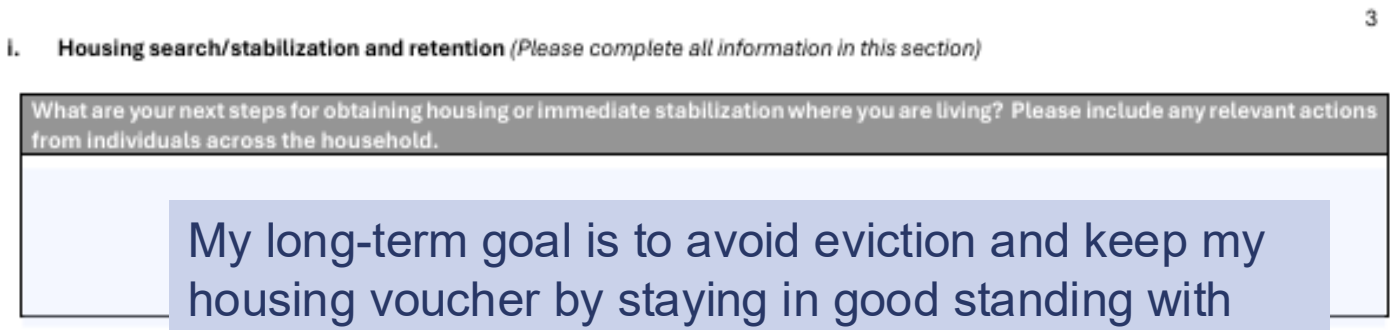
5

iii. **Health needs** *(Please complete all information in this section)*

What health needs (including mental health and substance use) help do you need assistance with to be successful in obtaining a home, stabilizing your living situation, and/or meet other important needs? Please include any relevant needs from individuals across the household that may impact ability to obtain and maintain housing.

- There are three goal sections in the HSP. **You need at least one goal in each section.**
- The plan should include both **long-term and intermediate goals.**
- What you write in these narrative boxes will also be entered into the "Goal" section of the "Activities" section.
- Use **SMART goal framework** to ensure goals are specific to the member, measurable, attainable, relevant to HSP, and time-bound.
- Note: intermediate goals should be achievable within 3 months

Goal Setting: Housing Stabilization and Retention



3

i. **Housing search/stabilization and retention** *(Please complete all information in this section)*

What are your next steps for obtaining housing or immediate stabilization where you are living? Please include any relevant actions from individuals across the household.

My long-term goal is to avoid eviction and keep my housing voucher by staying in good standing with my landlord.

My intermediate goals are to:
1) Pay rent on time each month for the next 3 months to rebuild trust with the landlord; and
2) Establish routines to support recovery and help avoid any formally reported complaints with the neighbors for the next 3 months

Specific
These goals are specific, rather than vaguely stating "pay rent" or "stay housed" They are also specific to the client (recall connection between recovery and housing in client's initial statement)

Measurable
Can clearly measure whether or not his rent is paid on time, and whether a formal complaint is lodged against him with the landlord

Attainable
Intermediate goals are things that the client believes they can realistically achieve, ex: avoid formal complaints vs. avoid conflict

Relevant
Intermediate goals are connected to larger themes such as Mr. Smith's overall goal for housing, and his long-term rebuilding trust with landlord and neighbors, and clearly relate to the Housing Supports Program

Timebound
Intermediate goals give specific timeframe of 3 months

Action Planning: Housing Stabilization and Retention

Housing search/stabilization and retention activities. Please include any relevant activities from individuals across the household.					
Goals:	**Actions:**	**Person Responsible:**	**Target Date to Complete:**	**Progress update:**	**Date Completed:**

- The first four columns should be filled out for at least one goal and action
  - Each of the three areas must have at least one goal and each goal must have at least one action, but it's likely you will have more than one
- "Person responsible" should be specific (name and indication of their role)
- If you had multiple goals in the previous box, ensure they are copied into the first column in the Activities grid.
- If submitting for a reauthorization after the first 180-day period, the plan must demonstrate clear accomplishments or progress.

Action Planning: Housing Stabilization and Retention

Goals	Actions	Person Responsible	Target Date to Complete
Pay rent on time for the next 3 months	Build routine for delivering rent check to landlord	Mr. Smith and case manager	6/30/26
	Establish communication and back-up plan to pay rent if hospitalized or other barrier arises	Mr. Smith with landlord	6/30/26
	Pay rent on time in June, July and August	Mr. Smith	8/31/26
Establish routines to support recovery and help avoid formal complaints from neighbors	Find and attend Group weekly at least 3 of 4 wks/month in June, July and August	Mr. Smith	8/31/26
	Wellness activity 3x a week (meditation, yoga, walk or volunteer)	Mr. Smith	8/31/26

- The first four columns should be filled out for at least one goal and action
  - Each of the three areas must have at least one goal and each goal must have at least one action, but it's likely you will have more than one
- "Person responsible" should be specific (name and indication of their role)
- If you had multiple goals in the previous box, ensure they are copied into the first column in the Activities grid.

Maintaining the HSP

Goals	Actions	Person Responsible	Target Date to Complete	Progress Update (updated 6/30/26)	Date Complete
Pay rent on time for the next 3 months	Build routine for delivering rent check to landlord	Mr. Smith and case manager	6/30/2026	At 6/7 touchpoint, case worker helped Mr. Smith learn how to pay rent through portal so he doesn't have to physically deliver a check	6/7/26
	Establish communication and back-up plan to pay rent if hospitalized or other barrier arises	Mr. Smith with landlord	6/30/2026	On 6/15 phone call, Mr. Smith reported that he and landlord discussed plan if admitted to hospital. Mr. Smith gave his daughter portal access to pay rent online as back-up	6/15/26

- If submitting for a reauthorization after the first 180-day period, the plan must demonstrate clear accomplishments or progress.
- The HSP is a living document and should evolve as the member progresses (new goals can be added, completed goals removed, etc)
- Activity at touchpoints should relate to goals and actions in the plan

Income Goals & Actions

ii. **Income/expenses/other resources** *(Please complete all information in this section)*

What is your overall monthly income goal? Please enter a dollar amount. Please enter both your individual goal and the total goal of the entire household (individual goal may be $0 if other household members are expected to earn income)

- For the income section, the monthly income goal must include a specific dollar amount, both for the individual and the total household
- This section can relate to topics such as:
  - Employment
  - Government benefits
  - Reducing debt or expenses

Income Goals & Actions

II. **Income/expenses/other resources** *(Please complete all information in this section)*

What is your overall monthly income goal? Please enter a dollar amount. Please enter both your individual goal and the t
entire household (individual goal may be $0 if other household members are expected to earn income)

I receive SSI (in the amount of $1050) and TANF. After covering my portion of rent ($500), I am left with $550. My long-term goal is to manage my monthly expenses responsibly.

My intermediate goals are to:

1) catch up on the late fees ($150) that have accrued to repair good will and trust with my landlord.
2) have a routine and schedule for paying my bills and managing expenses for the next 3 months.
3) work with my case manager to explore additional benefits or programs that can help stretch my SSI income further and reduce my risk of missing rent.

Specific
These goals are specific, rather than vaguely stating “pay rent” or “increase income”

Measurable
Can clearly measure whether or not he pays off his late fees

Achievable
Goals are things that the client can achieve, ex: pay his late fees, create a household budget and explore additional benefits.

Relevant
Goals are connected to larger themes such as rebuilding trust with landlord and stretching his fixed income further.

Timebound
Goals give specific timeframe of 3 months

Income Goals & Actions

Goals	Actions	Person Responsible	Target Date to Complete
Establish routine for paying my bills and managing expenses for the next 3 months	Identify and take a financial literacy course and complete a household budget	Mr. Smith and case manager	6/30/26
	Create monthly schedule for when to pay for groceries, rent, utilities, and other items	Mr. Smith and case manager	6/30/26
	Pay bills on time for the next 3 months	Mr. Smith	8/31/2026
Catch up on late fees of $150	Using household budget, figure out how much extra can go to the landlord each month to pay down fees	Mr. Smith	9/30/26
Explore additional benefits and programs to stretch SSI further	Brainstorm potential benefits and programs	Mr. Smith and case worker	6/30/26
	Apply or initiate connections with 2-3 potential programs	Mr. Smith and case worker	7/31/26

- The first four columns should be filled out for at least one goal and action (each of the three areas must have at least one goal and each goal must have at least one action)
- “Person responsible” should be specific (name and indication of their role)
- If you had multiple goals in the previous box, ensure they are copied into the first column in the Activities grid.

Maintaining the HSP

Goals	Actions	Person Responsible	Target Date to Complete	Progress Update (updated 6/30/26)	Date Complete
Establish routine for paying my bills and managing expenses for the next 3 months	Identify and take a financial literacy course and complete a household budget	Mr. Smith and case manager	6/30/26	• At touchpoint on 6/7, Identified financial literacy course offered by Camden County CC and enrolled Mr. Smith for 6/12 class. • On 6/15, Mr. Smith shared the household budget he completed in class.	6/15
	Create monthly schedule for when to pay for groceries, rent, utilities, and other items	Mr. Smith and case manager	6/30/26	**Delayed**. On 6/29, Mr. Smith requested working through this together with case manager at a future date.	
	Pay bills on time for the next 3 months	Mr. Smith	8/31/2026	At touchpoint on 6/29, Mr. Smith reported all June bills were paid on time.	

- If submitting for a reauthorization after the first 180-day period, the plan must demonstrate clear accomplishments or progress.
- The HSP is a living document and should evolve as the member progresses (new goals can be added, completed goals removed, etc)
- Activity at touchpoints should relate to goals and actions in the plan

Health Goals & Actions

III. **Health needs** *(Please complete all information in this section)*

What health needs (including mental health and substance use) help do you need assistance with to be successful in obtaining a home, stabilizing your living situation, and/or meet other important needs? Please include any relevant needs from individuals across the household that may impact ability to obtain and maintain housing.

- For the health section, actions should relate to the clinical risk factor that is checked off on the IAT, including mental health and substance use needs where relevant
- It is best practice to proactively flag any clinical needs for the MCO to help connect the member to other resources that may exist through their Medicaid plan

Health Goals & Actions

5

III. **Health needs** *(Please complete all information in this section)*

What health needs (including mental health and substance use) help do you need assistance with to be suc
home, stabilizing your living situation, and/or meet other important needs? Please include any relevant n
across the household that may impact ability to obtain and maintain housing.

I have been hospitalized six times this year due to my alcohol misuse, bipolar disorder and hypertension. My long-term goal is to stay out of the hospital.

My intermediate goal is to stay out of the hospital for the next 3 months by:

1) working with PCP and psychiatrist on the right meds
2) adhering to my med regimen
3) connecting with a support group for alcohol misuse

Specific
These goals are specific to Mr. Smith's health as described in his IAT rather than vaguely stating "improve health"

Measurable
Can clearly measure whether he stays out of the hospital for the next 3 months

Achievable
Goals are things that the client believes his can achieve, ex: work with his doctors to adjust his meds; connect with a support group

Relevant
Goals are connected to larger themes such as his diagnoses, staying out of the hospital to maintain his tenant responsibilities, and showing his daughter he can live independently

Timebound
Goals give specific timeframe of 3 months

Health Goals & Actions

Goals	Actions	Person Responsible	Target Date to Complete
Figure out the right medication regimen	Schedule and attend PCP visit to review hypertension medications and discuss side effects	Mr. Smith and case manager	6/30/26
	Get blood pressure cuff for home BP monitoring, working with MCO care management if necessary	Mr. Smith and case manager	7/15/26
	Schedule and attend psychiatry appointment to review treatment for bipolar disorder and get medication refills	Mr. Smith and case manager	7/15/26
	Adhere to medication regimen for three months	Mr. Smith	9/30/26
Connect with alcohol support group	Explore available groups in the area and identify one that is accessible weekly	Mr. Smith and Case Manager	7/15/26

- The first four columns should be filled out for at least one goal and action (each of the three areas must have at least one goal and each goal must have at least one action)
- "Person responsible" should be specific (name and indication of their role)
- If you had multiple goals in the previous box, ensure they are copied into the first column in the Activities grid.

Maintaining the HSP

Goals	Actions	Person Responsible	Target Date to Complete	Progress Update (updated 6/30/26)	Date Complete
Figure out the right medication regimen	Schedule and attend PCP visit to review hypertension medications and discuss side effects	Mr. Smith and case manager	6/30/26	Mr. Smith attended PCP visit on 6/22.	6/22
	Get blood pressure cuff for home BP monitoring, working with MCO care management if necessary	Mr. Smith and case manager	7/15/26	On 6/25, case manager called MCO care management team to understand process for getting cuff.	
	Schedule and attend psychiatry appointment to review treatment for bipolar disorder and get medication refills	Mr. Smith and case manager	7/15/26	Delayed. First available appointment was in September. Working with MCO to identify other options to connect with psychiatry.	

- If submitting for a reauthorization after the first 180-day period, the plan must demonstrate clear accomplishments or progress.
- The HSP is a living document and should evolve as the member progresses (new goals can be added, completed goals removed, etc)
- Activity at touchpoints should relate to goals and actions in the plan

Summary

Remember to use the Housing Stabilization Plan as a tool to stay connected, aligned and engaged with your clients, and to maintain communication with the MCO.

- Use this training as a guide for the level of narrative and detail to include in your Housing Stabilization Plan
- Provide a copy of the Housing Stabilization Plan to your client and review it together at your touchpoints
- Review and update this plan regularly (best practice: monthly)
- Resubmit to the MCO if there are any meaningful changes in the member's housing situation or level of need

Reminders

Reminders

- Next Office Hours: **MCO Round Robin on Wednesday 7/22 from 1-2:30pm**
- Submit your MCO-specific questions in advance using this link.
- DMAHS released another round of Readiness grants, open to new and existing HSP providers. **Submit your application here by July 31.**
- Bookmark the Housing Supports webpage here.
- Sign up for our Housing Supports Program newsletter here.
- Use our Help Desk Inquiry Form to ask your questions and get timely support

Camden Coalition