Hospital to Housing
Massachusetts Behavioral Health Partnership
Carelon Behavioral Health

# Hospital to Housing Member Referral Form

Date: _____ Referring organization name: _____

Staff member referring (name, title): _____

Staff member phone and email address: _____

Member's name: _____ DOB: _____ Gender: _____

Member's MassHealth ID #: _____ Member's phone #: _____

If Member's MassHealth ID # not available, please provide social security #: _____

Member's MassHealth plan, Accountable Care Organization (ACO), or Managed Care Organization (MCO):

Member's primary care practice (if known): _____

Names and contact information for other providers/case managers working with Member: _____

Member's current location (be as specific as possible, e.g., streets of Boston, woods in Quincy, Name of Transitional Living Center, inpatient at name of facility, etc.): _____

Member's desired location in which to secure permanent housing: _____

**Member eligibility:** Please check appropriate box below.

**Is this Member homeless?**

☐ Yes ☐ No

**Has this Member had at least three behavioral health or substance use hospitalizations over the past 12 months?**

☐ Yes ☐ No

If yes, please list all hospitalizations over the past 12 months (to the best of your knowledge; estimates are okay).

**Please provide a brief explanation of referral reason including Member's history of homelessness and hospitalizations. Please provide as much information on the Member's history as you have.**

If needed, please attach a separate page with any additional information regarding this referral.

***Please securely email this completed form to:*** hospitaltohousing@carelon.com.

*Updated 2024*