

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop: S2-25-26  
Baltimore, Maryland 21244-1850



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## State Demonstrations Group

January 7, 2025

Lisa Lee  
Commissioner, Department for Medicaid Services  
Cabinet for Health and Family Services  
275 East Main Street,  
Frankfort, KY 40601

Dear Commissioner Lee:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Health-Related Social Needs (HRSN) services protocol for the TEAMKY section 1115(a) demonstration (Project Numbers 11-W-00306/4 and 21-W-00067/4). We have determined the services protocol is consistent with the requirements outlined in the demonstration Special Terms and Conditions (STCs) and are therefore approving it. We are also approving the updated HRSN Services Matrix that aligns with this protocol approval. A copy of the approved protocol and matrix are enclosed and will be incorporated into the STCs as Attachments K and N.

We look forward to our continued partnership on the TEAMKY section 1115(a) demonstration. If you have any questions, please contact your project officer, Valisha Andrus at [Valisha.Andrus@cms.hhs.gov](mailto:Valisha.Andrus@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink that reads "Andrea J. Casart". The signature is written in a cursive, flowing style.

Andrea J. Casart  
Director  
Division of Eligibility and Coverage Demonstrations  
State Demonstrations Group

Enclosure

cc: Christine Davidson, State Monitoring Lead, Medicaid and CHIP Operations Group

## **Attachment K:** **Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications**

### **Services Protocol**

#### **List of Medicaid Covered Health-Related Social Needs (HRSN) Services**

Medicaid covered HRSN services and housing-related supportive services include:

1. Short Term Pre-Procedure Housing
2. Short Term Post Transition Housing

HRSN service description, frequency, duration, setting and provider requirements, and minimum eligibility criteria are described in Exhibit 1.

Eligible provider types and requirements for each service are indicated in Exhibit 2.

Services under the TEAMKY Recuperative Care Pilot benefit will be provided to individuals who reside and receive services in their home or in the community, not in an institution.

#### **Establish Eligibility and Medical Necessity for TEAMKY Recuperative Care Pilot HRSN Services**

##### **Eligibility:**

All Kentucky beneficiaries eligible through mandatory, optional, or expansion eligibility groups, receiving full Medicaid coverage, ages 18 or older, with income up to 213 percent of the federal poverty level (FPL), who meet the clinical and social risk factors described below, will be eligible for HRSN services.

Individuals eligible for the TEAMKY 1115 Recuperative Care Pilot must be experiencing homelessness or at risk of homelessness, as defined under federal regulation 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i). These definitions encompass a broad range of housing instability scenarios, such as individuals without access to a fixed, regular, and adequate over-night residence, or those at imminent risk of losing their primary housing due to financial hardship or other life circumstances.

Eligible individuals must also face a heightened risk of hospitalization or readmission and have specific aftercare needs. This includes those recently discharged from an acute care facility or

emergency department, as well as individuals requiring pre- or post-procedure care for planned medical interventions such as surgeries, chemotherapy, or other intensive treatments. The model provides critical support for stabilizing their medical condition during this vulnerable period.

To qualify, individuals must be at least 18 years of age, Medicaid eligible, have a primary medical diagnosis, be independently mobile (with or without the use of assistive devices), and capable of performing basic Activities of Daily Living (ADLs). These criteria ensure that participants are able to engage with the care provided while maintaining a level of personal independence crucial for successful recuperative outcomes. This targeted support aims to address the medical and social vulnerabilities of these individuals, fostering recovery and facilitating a pathway to long-term stability.

**Table 1. Eligibility Criteria**

<b>Eligibility Criteria Category</b>	<b>Age</b>	<b>Clinical and Social Risk Criteria Definition</b>
<b>Medicaid Eligible</b>	18+	All Kentucky beneficiaries eligible through mandatory, optional, or expansion eligibility groups, receiving full Medicaid coverage, ages 18 or older, with income up to 213 percent of the FPL, will be eligible for the HRSN service.
<b>Primary Medical Diagnosis</b>	18+	Individuals must have a documented primary medical diagnosis requiring post-acute care, preparation for planned medical procedures, or episodic treatment. This diagnosis serves as the foundation for determining the medical necessity of Recuperative Care Pilot services.
<b>Homelessness or Risk of Homelessness</b>	18+	Individuals experiencing homelessness or at risk of homelessness as defined by 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i).
<b>Hospitalization Risk</b>	18+	At risk of hospitalization or readmission with aftercare needs, including: <ul style="list-style-type: none"> <li>• Post-discharge from acute care or emergency department.</li> <li>• Planned medical procedures requiring preparation care.</li> <li>• Planned treatments (e.g., chemotherapy) requiring pre-/post-treatment care.</li> </ul>
<b>Physical Mobility</b>	18+	Must be independently mobile, with or without an assistive device.
<b>Activities of Daily Living</b>	18+	Able to perform ADLs.

The table above outlines the eligibility criteria for populations who will receive services under the Kentucky Department for Medicaid Services (DMS) Recuperative Care Pilot. This program focuses on individuals aged 18 and older who are experiencing homelessness or are at risk of homelessness, as defined by 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i). It also targets those at risk of hospitalization or readmission requiring post-discharge support, pre-procedure preparation, or ongoing treatment for conditions such as chemotherapy. Eligible individuals must be independently mobile, able to perform ADLs and have a primary medical diagnosis to ensure alignment with the program's goals of stabilizing health and reducing preventable hospitalizations.

### **Process for Identifying Medical Necessity for Recuperative Care Pilot Services**

The TEAMKY Recuperative Care Pilot employs a structured, comprehensive process to identify medical necessity and ensure services are aligned with the health and social needs of eligible individuals. Medical necessity is assessed upon referral, during admission, and throughout the individual's stay, using clearly defined criteria and evidence-based practices. This approach ensures that care is targeted, appropriate, and effectively meets the requirements of Medicaid-eligible individuals who are experiencing or at risk of homelessness.

Upon referral to a recuperative care program, an individual undergoes an eligibility screening to determine if they meet the core criteria: being at risk of or experiencing homelessness (as defined by 24 CFR 91.5), having a primary medical diagnosis, and facing hospitalization or readmission risks with specific aftercare needs. Examples of qualifying needs include post-acute discharge care, pre-procedure preparation, or episodic treatment such as chemotherapy. Additionally, the individual must be aged 18 or older, independently mobile (with or without assistive devices), and capable of performing basic ADLs.

Once admitted to the program, a **detailed nursing assessment is conducted within 24 hours by a licensed clinical professional with a minimum qualification of a Registered Nurse**. This assessment involves a comprehensive review of the individual's discharge instructions, vitals, living situation, patient and mental status, impairments, medication reconciliation, ADLs, and elimination needs. The findings of this assessment inform the development of a personalized care plan, ensuring alignment with the patient's medical, behavioral, and social requirements.

Daily evaluations are integral to monitoring and validating the ongoing medical necessity of services. Registered nurses perform daily wellness checks that include vital assessments, pain management, care plan reviews, and progress tracking. These evaluations assess compliance with treatment, participation in self-care, and any changes in condition that may require adjustments to the care plan. A key component of these checks is medication monitoring, which includes ensuring access to prescribed medications, educating patients on self-administration, and fostering independence in medication management.

Behavioral health services, when identified as medically necessary, are incorporated into the care plan. Licensed behavioral health practitioners provide screenings, brief interventions, and

referrals to community-based services as needed. Care coordination further supports the process by addressing social determinants of health (SDOH) and ensuring the integration of medical, behavioral, and social services. A care coordination plan is established within 72 hours of admission, including an assessment of medical, behavioral, and social needs, along with defined goals and regular reviews.

The TEAMKY Recuperative Care Pilot ensures that medical necessity is continuously evaluated, leveraging ongoing monitoring and assessments to address the dynamic needs of patients. This patient-centered approach, supported by highly trained staff and structured processes, allows the program to effectively provide targeted care for vulnerable populations, while fostering recovery and stability.

### ***Eligibility Screening***

The state's comprehensive assessment tool is designed to support Kentucky residents in identifying and addressing their needs across various SDOH.

The tool will have a bi-directional connection with Kentucky's health information exchange to share SDOH information captured by a patient's provider to resources, so community providers can better understand resident needs. The assessment tool will also allow for a **closed-loop referral process** to guide improved outcomes, strengthen partnerships, and promote wrap around services to residents. By using the eligibility assessment, Kentucky residents can proactively identify areas where they need support and connect with the appropriate local resources. This valuable tool not only helps individuals address their immediate needs, but also empowers them.

## **Clinical Criteria Considerations for Kentucky's Recuperative Care Pilot**

The TEAMKY Recuperative Care Pilot establishes robust clinical criteria and an administrative process to streamline eligibility determination and ensure effective communication among community partners. This integrated approach ensures that Kentucky Medicaid members receive timely, medically necessary services while maintaining alignment with program requirements and Medicaid guidelines.

### ***Eligibility Determination and Administrative Coordination***

Eligibility for the TEAMKY Recuperative Care Pilot is based on a comprehensive evaluation of clinical and social criteria, including homelessness or risk of homelessness as defined by 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i). Individuals must be at least 18 years old, independently mobile (with or without assistive devices), able to perform ADLs and possess a primary medical diagnosis. Additionally, the pilot targets those at risk of hospitalization or readmission who require post-acute care, pre-procedural preparation, or episodic treatment such as chemotherapy.

To facilitate this process, Kentucky Medicaid will designate a centralized point of contact to validate member eligibility. Providers initiate the eligibility verification process by submitting referrals to this point of contact, who ensures alignment with the established criteria. This

administrative entity communicates verified eligibility to relevant individuals, including physical and behavioral health providers, Managed Care Organizations (MCOs), and Recuperative Care Pilot providers. The streamlined communication process minimizes delays and ensures that members receive services efficiently.

### ***Member Eligibility Process***

The member eligibility process begins with a detailed assessment conducted upon referral. Licensed clinical staff evaluate the individual's medical and social conditions, verifying alignment with the program's criteria. If deemed eligible, the state designated administrative point of contact ensures that the member's information is updated and shared with MCOs and care providers. Eligibility is reassessed periodically throughout the member's stay to ensure that services remain appropriate to their evolving needs. This ongoing evaluation safeguards resources while maintaining high-quality care.

### ***Managed Care Organization Requirements***

MCOs play a pivotal role in the Recuperative Care Pilot by coordinating care and facilitating seamless transitions between medical and social services. They are required to integrate recuperative care into their service offerings, collaborating closely with Kentucky Medicaid and Recuperative Care Pilot providers. MCOs must also track outcomes and report utilization metrics, ensuring accountability and continuous improvement of the program.

### ***Information Transparency on Kentucky DMS Website***

To promote transparency and accessibility, Kentucky DMS provides comprehensive information about the Recuperative Care Pilot on its official website. This includes eligibility criteria, clinical and social risk criteria, program requirements, and details on the administrative processes. By maintaining a centralized repository of information, Kentucky DMS empowers providers, MCOs, and members to understand the program's scope and navigate its processes effectively. This open communication fosters trust and ensures consistent application of clinical criteria across the state.

Through these administrative and clinical processes, the TEAMKY Recuperative Care Pilot ensures that Medicaid members receive appropriate, patient-centered care while maintaining efficiency and accountability in service delivery. This approach reflects Kentucky's commitment to addressing health-related social needs and improving outcomes for its most vulnerable populations.

### ***Member Medical Record Documentation and Secure Data Exchange via KHIE***

DMS is implementing a robust process for gathering member medical record documentation and ensuring secure data exchange through the KHIE. This process supports the TEAMKY Recuperative Care Pilot by enabling efficient communication among providers, MCOs, and other community partners. These efforts are essential to ensure high-quality, coordinated care for Medicaid members experiencing homelessness or at risk of homelessness.

### ***Transparency and Provider Support***

Kentucky DMS will maintain a central repository of information about documentation requirements and KHIE participation on its official website. This resource will include detailed guidelines for providers, technical support for KHIE integration, and updates on program expectations. By fostering transparency and providing clear resources, DMS ensures that providers are well-equipped to meet the documentation and data exchange standards of the Recuperative Care Pilot.

Through meticulous record-keeping and secure data exchange, DMS's integration of KHIE into the Recuperative Care Pilot enhances the efficiency, quality, and continuity of care for Medicaid members. This initiative underscores Kentucky's commitment to leveraging technology and innovation to improve health outcomes for its most vulnerable populations.

This structured approach ensures that HRSN care plans remain dynamic and responsive to each individual's needs, maximizing the potential for successful outcomes.

### **Care Plan Review: weekly review of patient's plan of care by Recuperative Care Pilot care team. Integration with Kentucky's kynect resources**

The inclusion of Kentucky's kynect resources platform enhances the care planning process by providing members with access to a broad network of local programs and services. The platform's Eligibility Assessment helps care teams identify and prioritize SDOH-related needs, ensuring that referrals to housing support, food pantries, and transportation assistance are tailored to the member's circumstances. This integration allows care plans to address not only medical issues but also the social barriers that impact health outcomes.

### **Ongoing Review and Adaptation**

The care coordination plan is designed to be dynamic, with ongoing reviews conducted weekly or as needed to reflect changes in the member's condition. Adjustments are made to ensure the plan continues to meet the member's evolving needs, such as changes in medical status, behavioral health priorities, or access to resources.



## EXHIBIT 1: Breakdown of HRSN Services

The following reflects breakdown of HRSN services comprehensively, highlighting the nuanced categories and requirements, specifically the structure for both pre-procedure and post-transition housing under the program.

### 1. Short-Term Pre-Procedure Housing

**Table 2. Short-Term Pre-Procedure Housing**

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
<p>Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including:</p> <ul style="list-style-type: none"> <li>Short-term pre-procedure housing, where a provider has determined that preparatory steps are required for an upcoming procedure or treatment and integrated, clinically oriented recuperative or rehabilitative services and supports are provided.</li> </ul>	<p>Provided on an as-needed basis, depending on the individual's pre-procedures preparation schedule and care plan.</p> <p>Short term pre procedure housing services can be provided for more than one stay for up to 6 months in a rolling year if determined medically necessary and patient meets eligibility criteria</p>	<p>Duration depends on the specific pre-procedure needs, typically ranging from 1 to 7 days prior to the procedure.</p> <p>Short term pre procedure housing services can be provided for more than one stay, not to exceed 6 months in a rolling year, if determined medically necessary and patient meets</p>	<p>Must be a recuperative care facility with:</p> <ul style="list-style-type: none"> <li>24/7 staffing by clinical professionals, allied health professionals, and/or paraprofessional staff.</li> <li>Daily wellness checks, vital sign monitoring, and pain management.</li> <li>Medication monitoring and secure double-locked storage.</li> <li>Capability to provide 3 meals per day.</li> <li>Capability to arrange for transportation for follow-up appointments, and access to</li> </ul>	<ul style="list-style-type: none"> <li>Must be Medicaid eligible.</li> <li>At least 18 years of age.</li> <li>Have a primary medical diagnosis requiring a planned procedure.</li> <li>Must be independently mobile, with or without assistive devices.</li> <li>Capable of performing basic ADLs.</li> <li>Demonstrates risk of hospitalization or other adverse outcomes without housing support during the pre-</li> </ul>



Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
		<p>eligibility criteria</p> <p>There is a total combined cap of 6 months for both Short-term pre-procedure housing and Short-term post-transition housing, per beneficiary, in any 12-month period.</p>	<p>telehealth services.</p> <ul style="list-style-type: none"> <li>• Staff trained in behavioral health, trauma-informed care, and motivational interviewing to support holistic recovery, and culturally responsive care.</li> <li>• Facilities must be accessible for individuals with mobility aids and capable of providing privacy for recovery.</li> <li>• Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from demonstrations.</li> </ul>	<p>procedure period as determined by licensed clinical staff. Measurement or determination uses a combination of clinical, social, and environmental factors. Such factors may include:</p> <ol style="list-style-type: none"> <li>1. Medical History and Clinical Risk – by evaluating the individual’s health status, comorbidities, and the complexity of the procedure to assess their vulnerability to complications.</li> <li>2. Social Determinates of Health – assessing factors such as lack of stable housing which is underway in this HRSN, access to healthcare, and availability of social support,</li> </ol>

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
				<p>which influence recovery and outcomes.</p> <p>3. Logistical Challenges – barriers to following pre-procedure instructions, attending appointments, or adhering to post-procedure care plans due to instability in living conditions.</p> <p>4. Clinical Judgment – considering input from healthcare providers who assess individual circumstances, including mental health, substance use, and ability to manage pre-procedure requirements.</p>

## 2. Short-Term Post-Transition Housing

**Table 3. Short-Term Post-Transition Housing**

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
<p>Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including:</p> <ul style="list-style-type: none"> <li>Short-term post-transition housing (e.g., post-hospitalization), where integrated, clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required.</li> </ul>	<p>Short term post transition housing services can be provided for more than one stay up to 6 months in a rolling year when determined medically necessary and patient meets eligibility criteria.</p>	<p>Typically lasts between 1 and 45 days, based upon medical necessity</p> <p>Short term post transition housing services can be provided for more than one stay, not to exceed 6 months in a rolling year, when determined medically necessary and individual's meet eligibility criteria</p> <p>There is a total combined cap of 6 months for both Short-term pre-procedure housing and Short-term post-transition</p>	<p>Must be a recuperative care facility with:</p> <ul style="list-style-type: none"> <li>24/7 staffing by clinical professionals, allied health professionals, and/or paraprofessional staff.</li> <li>Daily wellness checks, vital sign monitoring, and pain management.</li> <li>Medication monitoring and secure double-locked storage.</li> <li>Capability to provide 3 meals per day.</li> <li>Capability to arrange for transportation for follow-up appointments, and access to telehealth services.</li> <li>Staff trained in behavioral health, trauma-informed care, and motivational interviewing to support holistic recovery, and</li> </ul>	<ul style="list-style-type: none"> <li>Must be Medicaid eligible.</li> <li>At least 18 years of age.</li> <li>Upon discharge from a procedure or hospital stay requiring recovery support.</li> <li>Must have a primary medical diagnosis necessitating post-procedure care.</li> <li>Must be independently mobile, with or without assistive devices.</li> <li>Capable of performing basic ADLs.</li> <li>Demonstrates risk of readmission or complications without housing and support during the recovery period as determined by licensed</li> </ul>

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
		housing, per beneficiary, in any 12-month period.	<p>culturally responsive care.</p> <ul style="list-style-type: none"> <li>Facilities must be accessible for individuals with mobility aids and capable of providing privacy for recovery.</li> <li>Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from demonstrations.</li> </ul>	clinical staff. Measurement or determination uses a combination of clinical, social, and environmental factors.

## **Components of Short-Term Pre-Procedure and Post-Transition Housing Services**

The following are components within the Short-Term Pre-Procedure and Post-Transition Housing.

- **Nursing Services**
  - Nursing assessment within 24 hours of admission.
  - Daily wellness check conducted by licensed clinical staff (minimum RN).
  - Assessment of medical stability and ability to participate in care planning and self-care management.
- **Medication Monitoring**
  - Safe and secure medication storage (preferably double-locked).
  - Medication reconciliation to ensure accuracy and appropriateness of prescribed treatments.
  - Education and skill-building on medication self-management. Clinical staff provide training to promote independence in medication use, including adherence strategies and managing side effects.
  - Support accessing prescribed medications from local pharmacies or hospitals. Recuperative care staff coordinate with pharmacies to ensure timely delivery and availability of medications.
- **Behavioral Health Services**
  - Behavioral health screening
  - Screenings identify behavioral health needs and risk factors, leading to appropriate referrals or brief intervention.
  - Access to on-site or community behavioral health services for ongoing care. Staff provide brief interventions, or make appropriate referrals for behavioral health.
  - Brief interventions and referrals for severe or escalating behavioral health needs.
- **Care Coordination**
  - Care Coordination Plan developed within 72 hours of admission.
  - Onsite care coordination for aftercare appointments (medical, behavioral health, ancillary services).
  - Screening and referral to community-based services for SDOH needs.
  - Linkage to a Primary Care Physician (PCP) if one is not already established.
- **General Recuperative Care Services**
  - 24-hour staffed program with clinical and non-clinical support.
  - Provision of three meals daily
  - Secure storage for personal belongings and telecommunication access for medical purposes.
  - Wellness checks by medical professionals.
- Coordination of transportation to medical appointments, housing services, or community resources

## Exhibit 2: HRSN Services Provider Types and Requirements

A new provider type will be created through program integrity and recuperative care providers will need to apply to become the newly established provider type to be reimbursed by Kentucky Medicaid for recuperative care services through the pilot program. Providers will be reimbursed by a per diem rate for the provision of services, which meet the criteria that Kentucky Medicaid has set for the service. The provider types will also need to be registered through the National Institute for Medical Respite Care (NIMRC) Directory to qualify for certification once it becomes available. Providers will be expected to adhere to the national standards of recuperative care set forth by NIMRC. Self-attestation will be a mandatory requirement.

**Table 9. HRSN Services Provider Types and Requirements**

Service	Eligible Provider Type/Setting	Certification	Other Standard (if applicable)
Short-term Pre-Procedure Housing.	Recuperative care facility, interim housing, or medical respite setting. Staffed 24/7 by licensed clinical professionals, allied health professionals, or paraprofessional staff.	Listed on the NIMRC Directory and follows NIMRC standards of care.	Meets all requirements listed in Exhibit 1.
Short-term Post-Transition Housing.	Recuperative care facility or other approved setting with 24/7 staffing by licensed clinical personnel, allied health professionals, or paraprofessional staff.	Listed on the NIMRC Directory and follows NIMRC Standards of Care.	Meets all requirements listed in Exhibit 1.

**Attachment N: HRSN Service Matrix**

Target Populations	Service	All full-benefit Medicaid eligibles age 18 and over who meet social and clinical risk criteria
Housing Services with Room and Board	Short-term pre-procedure and/or post-hospitalization housing	<b>X</b>
	Short-term post-transition housing	<b>X</b>

	Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Housing Services with Room and Board	Short-term pre-procedure housing	All full-benefit Medicaid eligibles age 18 and over who meet social and clinical risk criteria	Individuals who are homeless, or at risk of homelessness	Have a primary medical diagnosis, and are at risk of hospitalization and/or readmission with a medical need and: Have a planned medical procedure requiring preparation care, or Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care prior to the treatment
	Short-term post-transition housing	All full-benefit Medicaid eligibles age 18 and over who meet social and clinical risk criteria	Individuals who are homeless, or at risk of homelessness	Have a primary medical diagnosis, and are at risk of hospitalization and/or readmission with a medical need following discharge from acute care facility or Emergency Department, or Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care following the treatment

Clinical Risk Factor	Clinical Criteria Detail
<b>Risk Factor 1</b>	Have a primary medical diagnosis, and are at risk of hospitalization as determined by licensed clinical staff and/or readmission with a medical need: 1) following discharge from acute care facility or Emergency Department, or 2) Have a planned medical procedure requiring preparation care, or Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care prior to or following the treatment

Social Risk Factor	Social Criteria Detail
<b>Risk Factor 1</b>	Individuals who are homeless, or at risk of homelessness who meet criteria based upon definitions in 24 CFR 91.5, except for the annual income requirement in 24 CFR