

POLICY AND PROCEDURE	
Title: Transitional Rent	
Primary policy owner: Utilization Management	Policy #: UM 93
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐ All Departments 2) ☒ Behavioral Health & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☒ Case Management (CM) 5) ☐ Claims (CLMS) 6) ☒ Community Marketplace & Member Engagement (MAR) 7) ☐ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☐ Cultural & Linguistics (CL) 11) ☒ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☐ Pharmacy (PH) 17) ☒ Provider Networks (PRO) 18) ☒ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☒ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☒ Medical Management (MM)
Product Type: ☒ Medi-Cal ☐ D-SNP	Supersedes Policy Number: New

I. PURPOSE

This policy is intended to outline the guidelines for the provision of Transitional Rent to Health Plan of San Joaquin and Mountain Valley

Health Plan ("Health Plan")s eligible members who are experiencing or at risk of homelessness.

II. POLICY

- A. Effective January 1, 2026, or such data as established by DHCS, Health Plan will provide Transitional Rent, a mandatory Community Support, to those members eligible for the service in Alpine, El Dorado, San Joaquin and Stanislaus Counties.
 - 1. Health Plan Members meeting the Behavioral Health population of focus (POF) will be the first to receive this service.
 - a. Health Plan Members in this POF may access rental subsidies funded through Behavioral Health Service Act (BHSA) housing interventions following their receipt of Transitional Rent, making Transitional Rent not a temporary reprieve from homelessness, but a pathway to long-term housing stability.
 - b. Additional Transitional Rent-eligible POFs will be included as provided by future guidance from the Department of Health Care Services (DHCS).
- B. Transitional Rent will cover up to six months' (182 days) rental and housing frees per demonstration period subject to a six-month global cap on room and board services within a six-month period for Health Plan Members, which may not be consecutive.
 - 1. Recuperative Care and Short-term Post-Hospitalization Housing are also included in the six-month global cap for room and board services.
 - 2. These two services cannot exceed more than six months in a rolling 12-month period
- C. Transitional Rent may be used to cover:
 - 1. Rental assistance in intermittent or permanent settings,
 - 2. Storage fees, amenity fees, and landlord-paid utilities that charged as part of the rent payment

- D. Health Plan members must meet the eligibility criteria outlined in DHCS Community Supports Policy Guide Volume 2, which includes the following:
1. Clinical risk factors, and
 2. Social risk factors, and
 3. Transitioning population, or
 4. Experiencing unsheltered homelessness, or
 5. Eligible for full-service partnership (FSP).
 - a. Members meeting FSP do not need to meet an additional transitioning population requirement.
- E. A Health Plan provider may use housing deposit community support for coverage of additional expenses not provided under Transitional Rent.
- F. Health Plan Members' housing may be provided in a permanent or interim setting, or provided for some months in an interim setting and the remainder in a permanent setting.
1. Interim housing may be appropriate when permanent housing is not available, where this is no lease agreement, or a lease term is not renewable.
 2. Permanent housing are those settings with a renewable lease agreement with a term of at least one month.
 3. Health Plan may not exclude coverage of any specific setting type.
 4. Health Plan Member placement should be driven by the needs and preferences of the member and the unique characteristics of the counties Health Plan services.
- G. Health Plan ensures settings required by DHCS are compliant with applicable U.S. Department of Housing and Urban Development (HUD) quality standards or habitability as required by state law.
1. Transitional Rent providers must conduct a basic unit or setting inspection to verify compliance with HUD standards or state habitability standards.
 2. Attestation of compliance with the standards identified in i. above must be submitted by the Transitional Rent provider as a condition of authorization to the health plan.

3. Health Plan must ensure that members are placed in setting that meet the minimum quality standards.
- H. Health Plan Members may obtain family housing, which is a setting that is appropriate to accommodate the family members, which may include a partner, spouse or one or more children,
1. The member should be housed in a setting that provides the smallest number of bedrooms to accommodate the members family without overcrowding and meets the family's needs, including the unique needs of individuals with disabilities and pregnant and postpartum individuals and families.
- I. Health Plan Transitional Rent providers are the entity that issues payment for housing for Health Plan members receiving Transitional Rent or, alternatively, directly provides housing for members receiving transitions rent.
1. Health Plan contracts with County, and individual Transitional Rent providers, and flex pools, if available, to administer the service, rather than administer payments directly to landlords.
- J. The Health Plan contracted Transitional Rent provider is responsible for:
1. Identifying an appropriate setting/unit.
 2. Ensuring the housing unit is habitable.
 3. Helping member to review, understand, and execute the lease agreement, and assuring the lease agreement is compliant and legal.
 4. Structuring rent payment agreement with landlord or property owner.
 5. Issuing timely payments to the landlord or other housing provider.
 6. Coordinating with the supportive services including Housing Trio providers(Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, Housing Deposits) providers, Enhanced Care Management (ECM) provider and/ or other

Medi-Cal or non-Medi-Cal funded providers who may be involved in service delivery for the member.

7. Member housing is prioritized based on the uniqueness of the county/counties of operation.
8. Obtaining and providing documentation with authorization request of the members agreement to receive Transitional Rent.
 - a. The Transitional Rent Provider will document in the authorization request to health plan the members agreement to receive services and member data.
 - b. If the provider does not submit such information, Health Plan will reach out to the Transitional Rent provider to obtain a verification of the members' agreement to receive services
- K. In accordance with Health Plan policy CONT 01 Provider Contracting: Review and Execution of Provider Contracts, Transitional Rent providers that have a state-level enrollment pathway must enroll in the Medi-Cal program if such pathway exists.
 1. For providers who do not have a state enrollment pathway, Health Plan will have a process for vetting these providers as outlined in Health Plan Policy QM 47 Initial Assessment, Verification, and Ongoing Monitoring of Facility and Ancillary and Organizational Providers.
- L. Health Plan members receiving Transitional Rent will be encouraged to complete an intake into the coordinated entry system.
 1. This will assist members in connecting to housing services.
- M. Health Plan will make best efforts to ensure that all instances of Transitional Rent are recorded in Housing Management Information System (HMIS).
 1. HMIS entry will be required effective January 1, 2027.
- N. Health Plan has an equitable, nondiscriminatory, and timely authorization process in place to determine member eligibility for each community support, in accordance with the service definitions and Health Plans contract with DHCS. Corrective action will be implemented if evaluation findings identify instances where service authorizations have been inequitable or discriminatory.

1. Health Plan communicates to members and providers regarding the documentation of the medical appropriateness of the community support.
 - a. Communications include, but are not limited to, member newsletters, Health Plans website under member and provider information, the members evidence of coverage, through provider alerts distributed to all contracted provider, and multiple community-based forums including network providers in addition to those providing ECM and Community Support (CS) Services.
 - b. Referral and authorization requirements for the 14 additional community support services Health Plan offer described in Health Plan Policy UM 50 Community Supports.
- O. Health Plan will not condition authorization for or continued receipt of Transitional Rent on sobriety engagement in or completion of certain serviced, or "housing readiness."
 1. A Health Plan member may choose to use Transitional Rent in recovery housing.
 - a. This is an option, but never the only option.
- P. Health Plan will ensure those members with an approved Transitional Rent authorization also are automatically authorized for the services listed below through review of daily episode inventory and productivity reports, which will identify that the authorizations have been processed through the medical management system. The services that will be authorized at the time of Transitional Rent authorization:
 1. Housing Transition Navigation Services (HTNS),
 2. Housing Deposits,
 3. Housing Tenancy and Navigation Services (HTSS)
 - a. HTNS, Housing Deposits, and HTSS are referred to as the "Housing Trio."
 4. Enhanced Care Management.
- Q. Members are referred to a Transitional Rent provider, at the time of identification, from a variety of sources, including Health Plan, County

Behavioral Health Agency, community-based health care provider, housing support services provider, continuum of care (CoC) provider, and a member self-referral.

1. The Transitional Rent provider will meet with the member and determine their need, as well as determine if the member meets the eligibility requirements.
 2. The Transitional Rent provider will submit an authorization request to Health Plan with all supporting documentation for review and determination.
- R. For Transitional Rent to be authorized, a Housing Support Plan must be developed, regardless of setting (Interim or Permanent).
1. If the member is receiving HTNS, this provider in conjunction with the member will create the housing support plan.
 2. Any Community Support provider, a flex pool or hub organization the coordinates supportive serviced, or other housing providers, including county behavioral health agencies, regardless of their participation in Medi-Cal or as a contracted provider.
 3. The housing support plan can and should be updated as a member's needs and other relevant circumstances change.
 4. Health Plan will engage providers to create the housing support plan through written communication, during the bi-monthly ECM/CS Provider meeting, via newsletters, provider alerts and by engaging the appropriate provider services representative to assist with those providers difficult to engage.
- S. The housing support plan must:
1. Identify the permanent housing strategy and solution for the member, including payment sources and mechanisms, that will support the member in maintaining housing after the

- room and board services covered under Medi-cal are exhausted.
2. Identify full range of permanent housing supports that will support the member in sustaining tenancy.
 3. Be informed by member preferences and needs and reviewed and revised as needed based on changes in the member circumstances.
 4. Be based on a housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the members' approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal may be required to meet the goal.
 5. Be developed in a way that is culturally appropriate, and trauma informed.
- T. To reduce the risk that Members placed in interim setting return to homelessness at the expiration of six months of Transitional Rent, Health Plan must ensure that the following are met prior to authorizing placement in an interim setting:
1. Coordinate with the Member's County behavioral health agency and confirm the Member is BHSA eligible and will be able to transition to BHSA Housing Interventions at the expiration of Transitional Rent.
 - a. This will occur if the member is not able to secure a HUD Housing Choice Voucher, permanent supportive housing subsidy, or other long-term rental subsidy to transition to at the end of Transitional Rent coverage.
 - b. This confirmation must be obtained regardless of whether the department is acting as the Member's

- Transitional Rent Provider and must be documented in the housing support plan for this Health Plan member.
- c. Documentation of the Members' eligibility to participate in BHSA will be shared with Health Plan by County behavioral health.
 - i. This documentation fulfills the requirement of the members housing solution in their housing support plan
 - 2. Health Plan requires a housing support plan be in place as outlined in Section II S & T on Pp. 7-8 of this policy.
- U. The County Behavioral Health Agencies may conduct streamlined provisional authorizations for those members in the Behavioral Health POF. These may only be conducted with the following conditions are met:
- 1. The county behavioral health agency is contracted with Health Plan as a Transitional Rent provider.
 - a. If the county behavioral health agency is not contracted with Health Plan to provide Transitional Rent, Health Plan will contract with independent providers in that specific service area.
 - 2. The county behavioral health agency determines that the member is BHSA eligible and commits to providing the member with BHSA housing interventions at the expiration of Transitional Rent, or upon denials of the request for coverage by Health Plan.
 - a. Due to the provisional authorization that county behavioral health has provided, denials should be infrequent by Health Plan and occur primarily in situations where the member has reached the global cap on receipt of room and board services
 - 3. The county behavioral health agency commits to sending a request for authorization to Health Plan in a timely manner

- and at a minimum, within 14 days of the county behavioral health agencies streamlined provisional authorization
- a. Authorization requests will be submitted through the provider portal or by Faxing the request to 209-942-6302.
 - b. Health Plan will confirm eligibility and process a request for authorization.
4. In accordance with DHCS APL 21-011 and Health Plan Policy UM 01: Authorization and Referral Review, Health Plan must authorize or deny of coverage of Transitional Rent within the shortest applicable timeframe, but no longer than five (5) business days from receipt of information reasonably necessary and requested to by Health Plan to make a determination, not to exceed 14 calendar days from the receipt of the referral from the county behavioral health agency.
 5. Health Plan and county behavioral health agencies will achieve partnership, collaboration and communication regarding BHSA housing interventions.
 - a. This will be achieved through current processes, such as, but not limited to:
 - i. Faxing of screening forms and screening tools to Health Plan's Behavioral health,
 - ii. Scheduled meetings to discuss members, identify members who will benefit from Transitional Rent, and
 - iii. Ad hoc meetings as needed to discuss member housing needs, especially those enrolled in County behavioral health with Specialty Mental Health Services (SMHS),

Drug Medi-Cal (DMC), and Drug Medi-Cal-Organized Delivery System (DMC-ODS).

V. Members will be identified for Transitional Rent through multiple channels, including, but not limited to:

1. Members currently receiving HTNS, Housing Deposits, HTSS, other community support services and ECM providers, drawing on the experience to date managing these members,
2. members that are homeless or at risk of becoming homeless,
3. Health Plan programs such as Case Management, Transitions of Care, Behavioral Health and Social Services, community providers,
4. County Behavioral Health, Homeless shelters, data from DHCS and review of Health Plan data identifying potential members.
5. Focus on hard-to-reach populations and those identified with significant mental health needs.

W. Health Plan shares each of the data elements included in the provider contract and the DHCS Community Supports Member Information Sharing Guidance with community supports providers, including Transitional Rent.

X. Health Plan discontinues, or de-authorizes Transitional Rent for members who no longer qualify for or no longer need the service.

1. A Notice of Action (NOA) will be sent to the provider and member in accordance with Health Plan Policy UM 07 Notice of Action for Delayed, Denied, Modified, or Terminated Services. The following scenarios will be tracked and monitored through review of claims and authorization review accomplished through reporting: Members meeting the global cap on coverage of Room and Board services

include Short-term Hospitalization Housing, Recuperative Care and Transitional Rent.

- a. Under the cap, coverage is limited to a combined six-months (182 days) of all Room and Board services per Health Plan member 12-month period.
2. Health Plan Members whose household received the maximum of six-months of Transitional Rent allowed under the BH-Connect demonstration period; and
3. Health Plan Members who transitioned to other housing programs or permanent setting.

III. PROCEDURE

A. Whenever an authorization request is received from a Transitional Rent provider, Health Plan Utilization Management (UM) staff reviews and makes a determination on the request in accordance with Health Plan Policy UM 01: Authorization and Referral Review.

1. All requests that do not meet the established Transitional Rent requirements will be sent to the Health Plan medical director, or peer physician reviewer to make the determination.
2. Health Plan authorizes these services based on the global cap on Room and Board services and the housing support plan, whose requirements are noted in Section II.S of this policy.
 - a. If the member has utilized any of the 182 global cap days, the authorization will be based on the remaining days left
 - b. A six-month authorization will be provided if none of the 182 global cap days have been used
 - i. Utilization of Room and Board services will be accomplished through claims and

authorization information available at the time of authorization

- c. Notification are sent to the member and provider with the determination for the Transitional Rent authorization request:
 - i. For approved services, members will be notified by mail and providers by fax,
 - ii. For adverse determinations of services requested, members and providers will be mailed a NOA in accordance with Health Plan policy UM 07 Notice of Action for Delayed, Denied, Modified, or Terminated Services.
 - d. Documentation of Room and Board days are documented within the authorization record and the housing support plan attached within the medical management system.
 - i. The housing support plan will be reviewed to ensure all elements are captured and are reflective of the plan for the member to obtain permanent housing.
- B. Health Plan does not re-assess eligibility while a Health Plan member is receiving Transitional Rent.
- 1. If a Health Plan member discontinues receipt of Transitional Rent after a period of less than 6-months (182 days), and then seeks to utilize Transitional Rent again, Health Plan must re-assess eligibility prior to authorizing.
 - 2. Members who transition from an interim to a permanent setting without discontinuing service, Health Plan may not reassess eligibility but may issue a new or revised authorization.
 - a. This authorization would reflect the remaining global cap that is available
 - 3. Transitional Rent coverage may be discontinued by Health Plan if the member's housing status changes to either be

HUD-assisted housing, move in with family or others reasons where they may no longer require the service.

C. Health Plan ensures each request for authorization is specific to the members needs and include:

1. A Housing Support Plan
2. Documentation demonstrating how the member meets eligibility requirements outlined in the DHCS Community Supports Policy Guide Volume 2.
 - a. ECM or Complex Case Management care plans to document member needs that qualify them for community support services.

D. Health Plan honors the community support authorization for members transitioning from another health plan.

1. Automatically authorize newly enrolled members and adapt the specifications to be consistent with parameters of Health Plan's community support.
2. Health plan engages the previous health plan, member, and/or community support provider to mitigate gaps in care.
 - a. Health Plan requests community support authorization information from the previous health plan
3. Health Plan reviews historical utilization data using a 90-day look-back period to identify members receiving community supports.
4. Health Plan tracks and applies Continuity of Care if members have not reached their applicable minimums.

E. In accordance with Section II, N. of this policy, Health Plan notifies the Housing Trio CSS Provider(s), the Transitional Rent Provider and the member of the approval and/or modifications to existing Housing Trio

authorization(s) to align with the Transitional Rent authorization. When Transitional Rent is authorized:

- F. If the member is not currently receiving Housing Trio CSS and the Transitional Rent Provider is contracted to provide same,, Health Plan will authorize the member to the same provider.
 - a. If the Transitional Rent Provider does not provide Housing Trio Servies, Health Plan will refer/authorize to a provider who provides all the Housing Trio Services.
 - b. If there is no available provider who provides all Housing Trio services, Health Plan will authorize to as few providers as possible to support effective coordination.
2. If the member is currently receiving ECM services and Housing Trio CSS, Health Plan will:
 - a. Inform the Transitional Rent Provider of which ECM/CCS entity(ies) providing these services to the member.
3. If the member is receiving ECM, but is not receiving Housing Trio CSS,, the member shall be authorized for these CSS services..
 - a. Health Plan will authorize the services with the existing ECM provider, if possible.
4. If the member is not currently receiving ECM services:
 - a. As soon as possible, but no later than three (3) business days from the authorization for Transitional Rent, the member will be referred and authorized to an appropriate ECM provider, per Health Plan Policy CM 73 Enhanced Care Management.
 - b. Health plan notifies the Transitional Rent provider and the member of the ECM authorization to ensure seamless coordination amongst the ECM and CSS

providers, in accordance with Health Plan Policy UM01 Authorization and Referral Review.

- G. The ECM provider is required to conduct weekly in-person outreach visits as soon as feasible and acceptable to the member,
1. Initiation of in-person outreach must occur within two weeks of beginning Transitional Rent.
 2. The member and Transitional Rent provider will be notified of any other provider(s) providing and/or authorized to provide CSS, to ensure seamless coordination across providers for Health Plan members.
 - a. A The notification is provided in accordance with Health Plan Policy UM01 Authorization and Referral Review.
 - b. Health Plan obtains support from an assigned Provider Service Representative to assist with communication with the CSS and/or ECM entities , as needed.
- H. Health Plan discontinues authorization for Transitional Rent for a member who no longer qualifies, no longer requires, or no longer wants to receive Transitional Rent, including:
1. A member has met the global cap on coverage of Room and Board services, as outlined in section II
- I. Health Plan sends a Notice of Action (NOA) to the member in accordance with Health Plan policy UM 07 Notice of Action for Delayed, Denied, Modified, or Terminated Services.
1. If the member was informed at the beginning of services when the service would end, a NOA is not required.
- J. Health Plan monitors and evaluates Transitional Rent authorizations through:
1. Quarterly audits performed by Health Plan Clinical Auditors,
 2. Interdepartmental monitoring to ensure staff are following all requirements,
 3. Current reporting process for over/under utilization, referral tracking, and
 4. Audit & Oversight annually, at minimum, perform audits that include file review and assess delivery of the benefit.

- a. Additional ad hoc audits may be performed based on deficiencies identified internally and externally.
- K. Health Plan monitors the utilization and/or outcomes resulting from the provisions of Transitional Rent at least quarterly and reports to the Clinical Operations and Quality Improvement Health Equity Committee (QIHEC) committees.
- L. Health Plan annually evaluates performance of the Community Supports program to determine if the program is a cost-effective, high-quality alternative to traditional Medi-Cal covered services or settings. Criteria that may be monitored may include:
 - 1. Emergency Department utilization
 - 2. Inpatient length of stay
 - 3. Readmission rates
 - 4. Member satisfaction
 - 5. Appeals and Grievances
 - 6. Provider Capacity
 - 7. MCAS and/or HEDIS quality metrics
- M. Health Plan updates its member and provider facing website annually, at minimum, to include:
 - 1. Up-to-date member and provider facing information about Community Supports and how to refer for services and request authorization,
 - 2. A short description of all Community Supports Health Plan offers that may not differ from DHCS' terminology
- N. Health Plan shares member data in accordance with DHCS Community Supports Member Information Sharing Guidance.
 - 1. Health Plan submits encounter data for community supports provided through the existing encounter data reporting mechanisms for all covered services for which the organization incurs any financial liability, whether directly or through subcontracts or other arrangements, using federal and state standards.
 - 2. Health Plan shares the following data elements, as necessary, with community supports providers in a manner most conducive to protecting member personal information, such as the Health Plan Provider Portal or a secure file transfer protocol (SFTP):

- a. Member Community Supports Authorization files as defined in the Community Supports Member Information Sharing Guidance Encounter and claims data Physical, behavioral, administrative and SDOH data (HMIS data).
- b. Reports of performance on quality measures/metrics from the Health Plan HEDIS team, as requested. Data from the Closed Loop Referral System will be provided

IV. ATTACHMENT(S)

- A. *Desk- Level Procedure (DLP) or Department Job Aide*
- B. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
- C. [Glossary of Terms Link](#)
- D. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

- A. 24 CFR Section 91.5., 982.402(b).
- B. 42 CFR section 438.3(e)(2).
- C. AB 133 14184.206(e)
- D. California Assembly, 2021 Reg. Sess. (CA 2021)
- E. California W&I Code section 5830(c)(2), 8526.
- F. CCR §§ 1941., 1941.1., 1941.3.
- G. Department of Health Care Services Community Supports Policy Guide Volumes 1 & 2.
- H. Department of Health Care Services All Plan Letter APL 21-011 Grievance and Appeal Requirement, Notice and "Your Rights" Templates
- I. Department of Health Care Services All Plan Letter APL 21-017 Community Supports Requirements
- J. Department of Health Care Services Community Supports Member Information Sharing Guidance, December 2024.
- K. Department of Health Care Services BHSA Policy Manual
- L. Exhibit A. Attachment III, Subsection 4.3.8, 4.5, & 5.2.11
- M. Health Plan Policy CM 73 Enhanced Care Management

- N. Health Plan policy CONT 01 Provider Contracting: Review and Execution of Provider Contracts
- O. Health Plan Policy QM 47 Initial Assessment, Verification, and Ongoing Monitoring of Facility and Ancillary and Organizational Providers
- P. Health Plan Policy UM 01 Authorization and Referral Review
- Q. Health Plan Policy UM 07 Notice of Action for Delayed, Denied, Modified, or Terminated Services
- R. Health Plan Policy UM 050 Community Supports
- S. SB 3216 The Behavioral Health Services Act (BHSA)

VI. REVISION HISTORY

Version*	Revision Summary	Date
001	New Policy- Increased detail to processes for coordination between ECM and CSS providers	10/20/25
002		
003		
004		
Initial Effective Date: 1/1/2026		
Published Date:08/20/2026		

VII. Committee Review and Approval To Be Completed by Compliance

Committee Name	Version	Date
Compliance Committee (CC)	001	08/14/2026
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee (PIC)		
• Audits & Oversight Committee (AOC)		
• Policy Review Committee (PRC)		

Quality Improvement Health Equity Committee (QIHEC)		
Quality Operations Committee (QOC)		
Grievance Committee (GC)		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare Services (DHCS)	DHCS Account Manager	001	01/30/2026
Department of Managed Care (DMHC)			

IX. Approval signature*

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy