

# Clinical Policy: Transition Assistance Expanded Benefit

Reference Number: FL.CP.BH.02

Date of Last Revision: 06/26

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## Description

Sunshine Health considers coverage of Transition Assistance when appropriate to support youth in establishing safe and stable housing as they transition out of the foster care system. This policy outlines eligibility criteria for Transition Assistance as an expanded benefit for Sunshine Health's Child Welfare Specialty Plan (CWSP) members.

## Policy/Criteria

- I. It is the policy of Sunshine Health that Transition Assistance as an expanded benefit is **medically necessary** when all of the following criteria are met:
  - A. Meets eligibility for, and is enrolled in, the Sunshine Health Child Welfare Specialty Plan on the date the request is received;
  - B. Is or has been residing in licensed out of home foster care for a minimum of six months immediately prior to the member's 18th birthday;
  - C. Member is between the ages of 18 to 21 years of age;
  - D. Member has demonstrated that they can benefit from transition assistance to establish safe and stable housing;
  - E. Service or item must be used for assistance such as rental deposits, turning on utility service, or household supplies such as kitchen supplies and appliances, linens, or furniture;
  - F. Service or supply must be used for the member directly;
  - G. Transition Assistance does not exceed \$500 total one-time benefit;
  - H. Requests for Transition Assistance may be received from Child Welfare Community Based Lead Agencies (CBCs), CBC sub-contracted Case Management Agencies (CMOs), and adult Child Welfare Specialty Plan members only;
  - I. The request must be submitted on the Sunshine Health approved Transition Assistance Request Form (see Attachment A - Transition Assistance Request Form). All information on the request form must be completed in full and include the following:
    1. Date of request;
    2. Name, address, phone number of CBC/CMO or adult member making request;
    3. If CBC/CMO is requestor, name of staff member making request;
    4. Member name, member date of birth and member Medicaid number;
    5. Items/services requested;
    6. Explanation of how the requested items/services support the transitioning youth in obtaining safe and stable housing;
    7. Description of the supporting documentation of the fund request, along with the attached supporting documentation;
    8. Total Transition Assistance amount requested;
    9. Supporting documentation describing specifics of the items or services, along with verification of the cost, must be attached to the Transition Assistance Request Form at

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the time of request. Examples of documentation are receipts, landlord statements of rental amounts or deposits, utility bills, website printouts of costs of household items, or a written estimate of services to be provided. Documentation should clearly demonstrate that the cost of the items or services is equal to the amount being requested.

- J. The completed Transition Assistance Request Form and supporting documentation are submitted via email to [CWtransitions@centene.com](mailto:CWtransitions@centene.com). If unable to access email, requests may also be submitted by fax to 1-855-478-2890 or by regular mail to Sunshine Health's Child Welfare Operations Department at P. O. Box 459089, Fort Lauderdale, FL 33345-9089. For those submitted by email, a "Confirmation of Receipt" email is automatically sent to the requesting party.

II. It is the policy of Sunshine Health that Transition Assistance as an expanded benefit is **not medically necessary** when the following one or more of the following criteria is met:

- A. Member has not been in licensed out of home foster care for a minimum of six (6) months immediately preceding the member's 18<sup>th</sup> birthday;
- B. Exceeded the maximum of \$500 total, one-time benefit.

### Background

Transition Assistance is a one-time fund of up to \$500 per young adult who is transitioning out of the foster care system up through age 21. This fund could be used to support youth who are transitioning out of the foster care system in establishing safe and stable housing and to cover related items that are not Medicaid covered benefits.

The goal is to provide alternative funding to support young adults transitioning out of the foster care system. The funds are intended to be used toward services and items that will support the transitioning youth in establishing safe and stable housing and are not Medicaid reimbursable. These funds could provide for assistance such as rental deposits, turning on utility service, or household supplies such as kitchen supplies and appliances, linens, or furniture.

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
T2038	Community transition, waiver, per service

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		09/18
System update; no review or revisions.		05/19
Annual review; no content changes		06/20
Annual review; no changes		07/21
Annual review; no changes		08/22
Transitioned policy to new state specific template and sent to market for approval; policy number changed from FL.UM.15.00 to FL.CP.BH.02. Annual review. Reworded some extraneous language with no clinical significance. Updated address information in I.J. References reviewed and updated.	08/23	
Annual review; Reworded language in Criteria II. with no clinical significance. Updated Transition Assistance Expanded Benefit Request Form-Attachment A. References reviewed and updated.	08/24	
Annual review. HCPCS code T2038 added. References reviewed and updated.	07/25	
Annual review. References reviewed and updated.	06/26	

**References**

1. FL.QI.11 Grievance and Appeal System Policy.
2. Agency for Health Care Administration. Statewide Medicaid Managed Care Expanded Benefits.  
<https://ahca.myflorida.com/content/download/25560/file/Health%20Plan%20Expanded%20Benefits%20Grid%202025%20-%202011-7-2024.xlsx.pdf>. Effective February 1, 2025.  
 Accessed May 12, 2026.
3. Thompson V. National Academy for State Health Policy. How state Medicaid programs serve children and youth in foster care. [https://www.nashp.org/wp-content/uploads/2022/05/NASHP\\_Foster-Care-Brief\\_final.pdf](https://www.nashp.org/wp-content/uploads/2022/05/NASHP_Foster-Care-Brief_final.pdf). Published May 2022.  
 Accessed May 12, 2026.

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### Attachment A



**SUNSHINE HEALTH CHILD WELFARE SPECIALTY PLAN**  
Transition Assistance Expanded Benefit Request Form

Date: \_\_\_\_\_

Name of Community Based Care (CBC)/Case Management Organization (CMO) staff person submitting form: \_\_\_\_\_

Name of CBC/CMO Agency: \_\_\_\_\_

Address of CBC/CMO: \_\_\_\_\_

Phone number of CBC/CMO: \_\_\_\_\_

**Adult Member ONLY**

Name of Adult Member: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

\*Note: Completion of a W-9 form is required by the adult member in order to process the transition assistance payment. Payment is made directly to the adult member.

Member Name: \_\_\_\_\_

Member Medicaid Number: \_\_\_\_\_ Member DOB: \_\_\_\_\_

1. Member is or has been residing in licensed out of home foster care for a minimum of six (6) months immediately prior to the member's 18th birthday (check one):  
 yes or  no. If no, please stop here. If yes, please complete the additional information below.

2. List items/services being requested:  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Please describe how this request supports the transitioning youth in establishing safe and stable housing.  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Description of supporting documentation submitted (appropriate supporting documentation MUST be attached in order to process).  
 \_\_\_\_\_  
 \_\_\_\_\_

Total transition assistance amount requested: \$ \_\_\_\_\_

- Email form and supporting documentation to [CWtransitions@centene.com](mailto:CWtransitions@centene.com)
- The form and supporting documentation can be faxed to 1-855-478-2890
- The form and supporting documentation may be mailed to: Sunshine Health 1301 International Parkway, Suite 400, Sunrise, FL 33323. Attention: Child Welfare Specialty Plan Department
- Please send any questions via email to [CWtransitions@centene.com](mailto:CWtransitions@centene.com)

Sunshine Health Internal Use Only:

Approved       Partial Approval       Denied

Signature of Director of Operations, Child Welfare Programs:  
 \_\_\_\_\_

If partially approved or denied, reason: \_\_\_\_\_

Date of determination: \_\_\_\_\_

Signature of VP, Child Welfare Programs: \_\_\_\_\_

1-855-463-4100  
TDD/TTY 1-855-953-8770      [SunshineHealth.com](http://SunshineHealth.com)

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CW\_Transition Assistance Expander

### Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

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benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members/enrollees**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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