

HIV/AIDS, Hepatitis, STI, TB Administration

# Housing Services

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

## I. SERVICE CATEGORY DEFINITION

Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a customer or family to gain or maintain outpatient/ambulatory health services.

Housing services provide transitional, short-term, or emergency housing assistance to enable a customer or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated annually, to guide the customer's linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:

- Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
- Does not provide direct core medical or support service but is essential for a customer or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

### **Program Guidance:**

RWHAP Part recipients and sub-recipients must:

- Have mechanisms in place to allow newly identified customers access to housing services.
- Assess every customer's housing needs at least annually to determine the need for new or additional services
- Develop an individualized housing plan for each customer receiving housing services and update it annually.
- Upon request, RWHAP recipients must provide HAB with an individualized written housing plan.
- The necessity of housing services for the purposes of medical care must be documented.

HRSA/HAB strongly encourages the institution of duration limits to housing services. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends consideration for using HUD's definition as the standard.

Housing services funds cannot be in the form of direct cash payments to customers and cannot be used for mortgage payments.

**NOTE:** RWHAP funds may not be used for rental deposits. Because rental deposits are typically returned to customers as cash, this would violate the prohibition on providing cash payments to customers. In some instances, deposits may be retained as payment (e.g., damage to the property). As such costs would additionally be unallowable, recipients cannot pay for a rental deposit using federal funds, program income generated from federal funds, or pharmaceutical rebates generated from federal funds. (*HRSA HAB RWHAP Housing Services FAQ 6/6/17*)

Case management is crucial to the success of all Ryan White funded housing services. Since Ryan White funds are funds of last resort, it is important for case managers to coordinate their efforts to access a wide range of customer-centered, culturally sensitive services to link their customers with all available entitlement programs, subsidized and affordable housing programs, utility and food assistance programs, as well as provide any employment or budgeting assistance that might be needed to ensure customer self-sufficiency and success.

## II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually, with recertification every six months. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

### A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting CD4 count and viral load. Laboratory results should be within 6 months of the date of certification.
2. **Residency:** The following are acceptable methods of meeting the burden for residency:
  - Current lease or mortgage statement
  - Deed settlement agreement
  - Current driver's license
  - Current voter registration card
  - Current notice of decision from Medicaid
  - Fuel/utility bill (past 90 days)
  - Property tax bill or statement (past 60 days)
  - Rent receipt (past 90 days)
  - Pay stubs or bank statement with the name and address of the applicant (past 30 days)
  - Letter from another government agency addressed to applicant

- Active (unexpired) homeowner's or renter's insurance policy
  - DC Healthcare Alliance Proof of DC Residency form
  - If homeless, a written statement from case manager or facility
3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

The following are acceptable forms of proof of income:

- Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
- A notarized letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
- Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A notarized statement from the applicant projecting current annual income must be included
- Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
- SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
- Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

## B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

### C. RECERTIFICATION (6 months) REQUIREMENTS

To maintain eligibility for Ryan White services, the customer must complete the six-month recertification process. Providers may elect to have customers sign a self-attestation of no change in eligibility at the six-month recertification.

## III. KEY SERVICE COMPONENTS & ACTIVITIES

Eligible Housing Services	
<b>Housing Referral Services:</b> Housing Referral Services, by a case manager or housing coordinator, include assessment, search, placement and advocacy services. These services may include assistance completing housing applications and referrals to housing services such as short-term rent, mortgage, utility or emergency housing services. Housing Referral Services are short-term and episodic in nature.	
<b>Housing Management/Coordination Services:</b> A variety of short-term Housing Case Management/ Coordination activities, including services to customers that are enrolled in residential treatment facilities for mental health or substance abuse and those that are transitioning out of the correctional system.	
<b>Emergency Housing:</b> Emergency Housing Services provide emergency or temporary shelter to prevent homelessness for a period of 90 days or less.	
<b>Transitional Housing:</b> Transitional Housing Services facilitate the movement of homeless individuals or families to permanent/stable housing. This short-term support, not to exceed 24 months, must be associated with case management services.	
<b>Shallow Rent Subsidy:</b> Shallow Rent Subsidies provide a voucher for a portion of rent based upon income for individuals with high rent burden (defined as $\geq 50\%$ of monthly income on rent). On-going subsidy assistance provides 20% of the current HUD Fair Market Rent (FMR) of the county of residence per month to help the customer pay rent. The subsidy is available for up to 24 months; however, the housing navigator and customer must re-apply for assistance and meet eligibility criteria every six months.	
HOUSING/ NEEDS ASSESSMENT	
Standard	Measure
To identify emergent customer housing issues and supportive needs. Each customer will participate in at least one interview with their assigned Housing Case Manager/Navigator within five (5) business days of determining Ryan White eligibility to complete the Housing/ Needs Assessment.	<p>The following information should be recorded in the customer file.</p> <ul style="list-style-type: none"><li>• Customer's financial resources including employment, income, access to entitlement or public assistance programs</li><li>• Customer's housing history and specific housing needs</li><li>• Customer's eligibility or ineligibility for other housing assistance programs</li><li>• Customer's health status, with specific documentation of physical limitations and/or disabilities</li><li>• Customer's social functioning and support systems</li><li>• Customer's emotional, substance use/abuse, mental health issues, and/or domestic violence that impact their ability to obtain and maintain stable housing</li></ul>

INDIVIDUALIZED HOUSING PLAN	
Standard	Measure
<p>The Individualized Housing Plan (IHP) should document short- and long- term measurable goals and objectives for housing, timeframes to achieve those, solutions to address barriers, and resources and services that are needed to help maintain housing stability, the assistance to be provided by the Housing Case Manager or Navigator, and customer attainment of the goals. It should be reviewed within 90 days and modified if necessary.</p> <p>Within five (5) business days of determining Ryan White eligibility, the Housing Case Manager or Navigator will develop the IHP collaboratively with the customer to be used for:</p> <ul style="list-style-type: none"> <li>• Housing assistance</li> <li>• Obtaining/staying in medical care</li> <li>• Securing employment and/or public benefits and for financial planning</li> <li>• Enrollment and completion of life skills/financial literacy course</li> <li>• Addressing other issues identified in the assessment as barriers to stable housing</li> <li>• Linkage to medical and supportive services that customer must access in order to continue receiving Housing services</li> <li>• Determining the completion of goals</li> </ul>	<p>Documentation of IHP in customer's record signed and dated</p> <p>The customer's and/or legal guardian's signature and date in the development process and agreement with the Plan on file</p>
SEARCH, PLACEMENT AND ADVOCACY	
<p>Providers must use and show search, placement, and advocacy within all available housing services. This will allow for the following:</p> <ul style="list-style-type: none"> <li>• Access and assistance with housing lists</li> <li>• Landlord and Tenant Issues/Interactions</li> <li>• Financial planning for the sustainability of housing</li> <li>• Applying for financial assistance and subsidized housing for renters</li> </ul>	<p>Documentation of search, placement, and advocacy process</p>
COORDINATION & MONITORING OF THE INDIVIDUALIZED HOUSING PLAN (IHP)	
<p>There must be at least one documented contact with active customers every 30 days or as dictated by customer need/plan. Scheduled home visits should occur, as needed. The Housing Case Manager or Navigator must assess IHP progress.</p>	<p>Documentation in the customer record should include:</p> <ol style="list-style-type: none"> <li>1. Customer progress toward objectives of the IHP</li> <li>2. Documentation of adjustment to the IHP, as necessary</li> <li>3. Referrals and linkages to programs and services</li> <li>4. Attendance and follow-up for medical and supportive service appointments</li> <li>5. Progress in obtaining long-term housing assistance</li> <li>6. Documentation of emergency situations as they arise, such as crisis intervention</li> </ol>
REFERRALS & LINKAGES	

The Housing Navigator will assist the customer in obtaining additional needs identified, such as child support needs, independent living skills, and connecting to family and social support networks. Housing Navigators will frequently need to provide referrals and linkages to manage matters related to substance abuse, mental illness, and co-occurring disorders, in addition to needs arising from the combination of low-income and HIV.	Documentation in file of referrals and linkages that were provided
<b>RE-ASSESSMENT OF HOUSING NEEDS</b>	
A re-assessment is a formal re-examination of the customer's condition, needs and resources to identify changes that occurred since the initial assessment or most recent assessment. The Re-assessment should occur no less than every six (6) months and include: <ul style="list-style-type: none"> <li>Review of customer's clinical, financial and support needs to identify changes and/or additional services needs</li> <li>Summary of progress in achieving goals in the IHP, and any IHP revisions, as necessary</li> </ul>	Documentation of reassessment in file
<b>TRANSITION &amp; DISCHARGE</b>	
<b>Standard</b>	<b>Measure</b>
<p>Customer discharged when HE/RR services are no longer needed, goals have been met, upon death or due to safety issues.</p> <p><u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not present to sign for the letter, it must be returned to the provider.</p> <p><u>Transfer</u>: If customer transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location.</p> <p><u>Unable to Locate</u>: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made.</p>	<p>Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable.</p> <p><u>Documentation</u>: Customer's record must include:</p> <ul style="list-style-type: none"> <li>Date services began</li> <li>Special customer needs</li> <li>Services needed/actions taken, if applicable</li> <li>Date of discharge</li> <li>Reason(s) for discharge</li> <li>Referrals made at time of discharge, if applicable</li> </ul>

<p><u>Withdrawal from Service</u>: If customer reports that services are no longer needed or decides to no longer participate in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies.</p> <p><u>Administrative Discharge</u>: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart.</p>	
CASE CLOSURE	
Standard	Measure
<p>Case will be closed if customer:</p> <ul style="list-style-type: none"> <li>• Has met the service goals</li> <li>• Decides to transfer to another agency</li> <li>• Needs are more appropriately addressed in other programs</li> <li>• Moves out of the EMA</li> <li>• Fails to provide updated documentation of eligibility status thus, no longer eligible for services</li> <li>• Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer</li> <li>• Can no longer be located</li> <li>• Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan</li> <li>• Exhibits pattern of abuse as defined by agency's policy</li> <li>• Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program</li> <li>• Is deceased</li> </ul>	<p>Documentation of case closure in customer's record with clear rationale for closure</p>

#### IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to

develop capacities needed for effective job performance. Agencies are also responsible for maintaining documentation of the appropriate education, qualifications, training, and experience in personnel files.

#### **Housing Navigator or Case Manager**

Minimum qualifications for Housing Navigators:

1. The Housing Navigator will need to have extensive experience working with individuals who are HIV+ and the chronically homeless population.
2. Associate's/Bachelor's Degree in health or human services related field preferred. High school diploma or GED required.
3. A minimum of 1 year past experience working with persons with or at high risk of HIV infection preferred.
4. Strong Written and verbal communication skills
5. Ability to work with diverse communities.

Minimum qualifications for all staff providing housing services:

1. Case managers, housing coordinators, or other professionals with a degree in health or human services related field, preferred. High school diploma or GED required.
2. A minimum of one-year experience working with persons with or at high-risk of HIV and chronically homeless population OR
3. Persons who are HIV positive and/or persons with a history of mental illness, homelessness, or chemical dependence with equivalent experience/training
4. Strong written and verbal communication skills
5. Ability to work with diverse communities

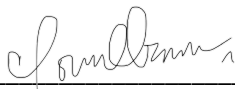
All professional housing providers must complete the following training within three (3) months of hire:

- a. Local, state, and federal housing program rules and regulations
- b. How to access housing programs
- c. HIV Case Management
- d. HIV and Behavioral Risk
- e. Substance Use and HIV
- f. Mental Health and HIV
- g. DC EMA CAREWare (for data-entry staff only)
- h. DC EMA Homeless Management Information System (for data-entry staff only)
- i. Culturally and Linguistically Appropriate Services
- j. Effective Communication

Staff participating in the direct provision of services to customers must satisfactorily complete all appropriate continuing education units (CEUs) either based on license requirement or should obtain 12 hours of continuing education per year. Training documentation on file maintained in each personnel record.

## **V. APPROVAL & SIGNATURES**

This service standard has been reviewed and approved on March 24 2021. The next annual review is March 2022.



Clover Barnes  
Division Chief  
Care and Treatment Division  
DC Health/HAHSTA



Sarcia Adkins  
Community Co-Chair  
Washington DC Regional Planning Commission  
on Health and HIV (COHAH)