SERVICE STANDARDS
FOR
HOUSING SERVICES

Origination date: SEPTEMBER 2016	
Reviewed/Approved by the Care Strategies, Coordination and Standards (CSCS) Committee	*3/15/17*
Approved by the Planning Council	*4/27/17*

The Ryan White HIV/AIDS Program (RWHAP) is funded by the Ryan White HIV/AIDS Treatment Extension Act of 2009 and is administered by the U.S. Department of Health and Human Services (HHS) in the Health Resources and Services Administration (HRSA) within the HIV/AIDS Bureau (HAB).

I. PURPOSE OF SERVICE STANDARDS

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 EMA such that clients 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 clients and will be used as contract requirements, in program monitoring, and in quality management.

II. GOAL

The goal of Housing Services is to assist People Living with HIV (PLWH) attain stable housing that supports consistent treatment adherence and retention in medical care.

III. SERVICE DESCRIPTION

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

Housing services provide transitional, short-term, or emergency housing assistance to enable a client 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 client'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 services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

The necessity of housing services for the purposes of medical care must be documented.

Program Guidance:

RWHAP Part recipients and sub-recipients must:

- Have mechanisms in place to allow newly identified clients access to housing services.
- Assess every client's housing needs at least annually to determine the need for new or additional services
- Develop an individualized housing plan for each client receiving housing services and update it annually.
- Upon request, RWHAP recipients must provide HAB with an individualized written housing plan.

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 clients and cannot be used for mortgage payments.

NOTE: RWHAP funds may not be used for rental deposits. Because rental deposits are typically returned to clients as cash, this would violate the prohibition on providing cash payments to clients. 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)*

IV. TYPES OF ELIGIBLE HOUSING SERVICES

Housing services may be provided through:

- Housing referral services
- Housing management/coordination services
- Short-term payments to vendors (Emergency/Transitional Housing)
- Establishment of voucher payments (Shallow Rent Subsidy)

Funds received under this service category may be used for the following housing-related expenditures:

- **Housing Referral Services:** 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.

- **Housing Management/Coordination Services:** A variety of short-term Housing Case Management/ Coordination activities, including services to clients that are enrolled in residential treatment facilities for mental health or substance abuse and those that are transitioning out of the correctional system.

- **Emergency Housing:** Emergency Housing Services provide emergency or temporary shelter to prevent homelessness for a period of 90 days or less.

- **Transitional Housing:** 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.

- **Shallow Rent Subsidy:** Shallow Rent Subsidies provide a voucher for a portion of rent based upon income for individuals with high rent burden (defined as **≥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 client pay rent. The subsidy is available for up to 24 months; however, the housing navigator and client must re-apply for assistance and meet eligibility criteria every six months.

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 client-centered, culturally sensitive services to link their clients 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 client self-sufficiency and success.

Applicants must show that they have searched for all other forms of housing to be eligible for Ryan White services. Documentation must include written letters from case managers, housing providers, street outreach workers, shelter staff, social workers as well as documentation of placement on other housing waitlists or applicable denial letters.

V. HRSA NATIONAL MONITORING STANDARDS AND PERFORMANCE MEASURE/METHOD

The National Monitoring Standards are designed to ensure that Ryan White service providers meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. Ryan White service providers will work with the recipient/administrative agent in their respective jurisdiction to further discuss the implementation of the National Monitoring Standards and the required performance measures. For this service category, the following performance measures are required:

Documentation that:

- The provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care.
- Housing-related referral services including housing assessment, search, placement, advocacy, and the fees associated with them.
    - Housing related referrals are provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs.
- For all housing, regardless of whether or not the service includes some type of medical or supportive services.
    - Each client receives assistance designed to help him/her obtain stable long-term housing, through a strategy to identify, re-locate, and/or ensure the individual or family is moved to or capable of maintaining a stable long-term living situation
- Housing services are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment.
- Mechanisms are in place to allow newly identified clients access to housing services.
- Policies and procedures to provide individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services.
- No funds are used for direct payments to recipients of services for rent or mortgages

VI. PROVIDER AGENCY POLICIES & PROCEDURES

A. Agency must be licensed and/or accredited by the appropriate city/county/state/federal agency, **if required.**
B. Staff must meet minimum qualifications detailed in the job description and service standards.
C. Services will be provided through the facility or through a written affiliation agreement.
D. **Records Retention** – Policies must exist for the production, maintenance and retention of client clinical records. The agency will keep inactive client records in a confidential locked location. Client records will be kept for seven (7) years.
E. **Confidentiality Policy -** All providers must assure the client that information provided by the client or information obtained on behalf of the client is confidential. All written and verbal communications regarding the client will be maintained with strict confidentiality according to the policy of the agency and in accordance to HIPAA (Health Insurance Portability and Accountability Act) requirements.
F. There will be a private confidential office space for seeing clients.
G. **Cultural and Linguistic Appropriateness** – The agency will adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Further information on the National CLAS Standards are located at www.thinkculturalhealth.hhs.gov . Agencies are to ensure that culturally sensitive and linguistically appropriate services are available in the client's preferred language or arrange for a certified interpreter. When providing medical services, the agency will arrange for a certified medical interpreter.
H. **Americans with Disabilities Act Compliance** – The agency must demonstrate that the needs of disabled clients are met.
I. **Client Consent** – Signed consent must be obtained from client prior to initiating services.
J. **Release of Information** - Written consent must be obtained to release/exchange client information. The

consent must be specific as to type of information, agency to which the information will be shared, and length of time during which the consent is valid.

K. **Grievance Policy**- All providers must review the policy with the client and provide a copy in a language and format the client can understand.
L. The Agency must have a written **Emergency Continuity of Operation Plan (COOP)** that includes procedures for service provision during a wide range of emergencies, including localized acts of nature, fire, bomb threat, evacuation, accidents, technological or attack-related emergencies and natural disasters.
M. Service providers must receive training/education annually in relationship to HIV, substance abuse, mental health, co-occurring disorders, health and related subjects such as "Prevention with Positives".
N. A **Quality Management Plan** shall be developed for HIV-specific patient care. This plan must be updated annually.
O. Agencies must maintain linkages via detailed Memoranda of Understanding/Agreement (MOUs/MOAs) among other agencies to enhance the coordination of service provision.
P. The agency must demonstrate input from clients via a client satisfaction survey or similar method at least annually.
Q. **Continuity of Care -** Agencies must ensure that service provision occurs regardless of staffing changes, shortages and closures. Clients must also be made fully aware of business operating hours and any changes, as needed.

VII. ACCESSIBILITY IN SERVICE DELIVERY

A. There will be no barriers due to client disability. The Agency must comply with ADA requirements for the provision of reasonable accommodations to address clients with special needs.
B. The agency must demonstrate a commitment to provide services that are culturally sensitive and linguistically appropriate in accordance to the National Standards for Culturally and Linguistically Appropriate Services (CLAS).
C. There will be no barriers due to language differences between the provider and clients. Agencies must have the ability to provide native language speakers for services when twenty percent (20%) or more of their clients prefer another language or arrange for a certified interpreter. When providing medical services, the agency will arrange for a certified medical interpreter.
D. Eighty percent (80%) of all persons initially seeking services will be established into the care system of the provider within five (5) working days of initial contact. If this is not possible, the reason must be documented in the client's file.

VIII. RIGHTS AND RESPONSIBILITIES

AGENCY/PROVIDER

A. Agencies funded for Ryan White services shall have the ability to provide service in non-English languages when twenty percent (20%) or more of the clients speak a specifically identified language and must provide information for clients in that language or arrange for a certified interpreter.
B. All written materials must be printed in a language that is understandable to the client and must be written at no higher than a 5th grade reading level.
C. The agency will have a Clients Rights Statement posted and available to the client upon request.
D. The agency will have a Consent for Services Form, which is dated and signed by the client or person legally able to give consent. This form will be signed by the client upon initial intake, and at least annually thereafter.
E. The agency will have a Release of Information Form that is specific to the type of information released/exchanged, the agency to which the information will be shared, and the length of time during which the consent is valid. This form is used as needed and is signed by the client or person legally able to give consent.
F. The agency will have a written policy related to Client Grievance Procedures which is reviewed with the client in a language and format the client can understand as stated in A.
G. The agency will have a written Client Confidentiality Policy in conformance with State and Federal Laws.
H. Agencies must provide clients with complete and accurate information about services provided.

CLIENT

I. Clients have the right to be treated with dignity and respect. Clients have the responsibility to treat other clients and agency staff/volunteers with dignity and respect.
J. Clients have the right to refuse services and receive a full explanation of the consequences of refusing services.

K. Clients must be an active participant in the development, implementation, coordination and monitoring of their individual service plans. Clients must be provided with complete and accurate information about services received.
L. Clients are responsible for providing complete and accurate insurance, medical, financial and other eligibility information.
M. Clients are responsible for respecting the confidentiality of other clients receiving services.
N. Clients have the right to file a grievance if they feel their rights are being violated. Clients are responsible for following the proper procedures as outlined for grievances against any services, organization, or employee of organization.
O. Clients have the responsibility to keep illegal drugs, alcohol and weapons off agency property.

SERVICES MAY BE DISCONTINUED OR DENIED WHEN:

P. The client refuses to sign a Consent for Services and Release of Information Form.
Q. The client violates the rights of other clients or staff/volunteers
R. The client is involved in illegal activities on agency property
S. The client does not provide accurate insurance, medical, financial or benefits information
T. The client is receiving duplicate services from multiple providers.
U. The client is no longer eligible for Ryan White Services.

IX. SERVICE DELIVERY COMPONENTS AND ACTIVITIES

A. INITIAL ELIGIBILITY DETERMINATION & ANNUAL RECERTIFICATION REQUIREMENTS

1. Proof of HIV diagnosis (Confirmatory HIV test [multi-spot, P4antigen, western blot], Viral load within 6 months, or written statement from treating physician).
2. Proof of residence (Current lease mortgage statement or deed settlement agreement, current driver's license/government identification, 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 your name and address (past 30 days), letter from another government agency with your name and address, active (unexpired) homeowners or renters insurance policy, DC Healthcare Alliance Proof of DC Residency Form, if homeless; letter from service provider on agency letterhead or homeless verification form.
3. Verification of income/gross annual income (must be less than or equal to 500% of the Federal Poverty Level [FPL]) as required by the Recipient.
4. Insurance verification as proof of un-insured or under-insured status.
5. Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare. Providers are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.
6. For under-insured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare.
7. Proof of compliance with eligibility determination as defined by the jurisdiction.
8. Living arrangements/Household size
9. Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for Ryan White services

B. INTAKE

To collect demographic information and establish a care relationship. Intake may be done by an Intake specialist or non-medical case manager. The client intake must include the following:

1. Date of intake
2. Name and signature of person completing intake
3. Client name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (client 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, Homeless Management Information System (HMIS), including the Vulnerability Index Service Prioritization Assistance Tool (VI-SPDAT) as appropriate
12. Any other service-specific data.
13. Documented explanation about the services available within the provider agency and within the Ryan White Program.

C. HOUSING NEEDS ASSESSMENT

To identify emergent client housing issues and supportive needs. Each client will participate in at least one face-to-face interview with their assigned Housing Case Manager/Navigator within five (5) business days of determining Ryan White eligibility to complete the Housing Needs Assessment.

The following information should be recorded in the client file.

- Client's financial resources including employment, income, access to entitlement or public assistance programs
- Client's housing history and specific housing needs
- Client's eligibility or ineligibility for other housing assistance programs
- Client's health status, with specific documentation of physical limitations and/or disabilities
- Client's social functioning and support systems
- Client's emotional, substance use/abuse, mental health issues, and/or domestic violence that impact their ability to obtain and maintain stable housing

D. INDIVIDUALIZED HOUSING PLAN (IHP)

Integrating housing with supportive services can significantly reduce the incidence of crises in clients' lives and improve their ability to remain stable in housing. This is crucial regardless of the level or type of housing assistance program being implemented. The Individualized Housing Plan (IHP) should document short- and long- term client goals for housing, resources and services that are needed to help maintain housing stability, the assistance to be provided by the Housing Case Manager or Navigator, and client attainment of the goals. It should be reviewed within 90 days and modified if necessary. Within five (5) business days of determining Ryan White eligibility, the Housing Case Manager or Navigator will develop the IHP collaboratively with the client.

The IHP should include the establishment of measurable goals and (short- and long-term) objectives, timeframes to achieve the objectives, solutions to address barriers and resources to be used for:

- Housing assistance
- Obtaining/staying in medical care
- Securing employment and/or public benefits and for financial planning
- Enrollment and completion of life skills/financial literacy course
- Addressing other issues identified in the assessment as barriers to stable housing
- Linkage to medical and supportive services that client must access in order to continue receiving Housing services
- Determining the completion of goals

Client Compliance Agreement: The client and/or legal guardian's signature and date are required to signify participation in the development process and agreement with the Plan.

E. SEARCH, PLACEMENT and ADVOCACY

Providers must use and show search, placement, and advocacy within all programming. This will allow for the following:

- Access and assistance with housing lists
- Landlord and Tenant Issues/Interactions
- Financial planning for the sustainability of housing

Applying for financial assistance and subsidized housing for renters

F. COORDINATION & MONITORING OF THE INDIVIDUALIZED HOUSING PLAN (IHP)

The needs and status of each client receiving Housing Services will be monitored. There must be at least

one documented contact with active clients every 30 days or as dictated by client need/plan. Scheduled home visits should occur, as needed. The Housing Case Manager or Navigator must assess IHP progress. Documentation in the client record should include:

1. Client progress toward objectives of the IHP
2. Documentation of adjustment to the IHP, as necessary
3. Referrals and linkages to programs and services
4. Attendance and follow-up for medical and supportive service appointments
5. Progress in obtaining long-term housing assistance
6. Documentation of emergency situations as they arise, such as crisis intervention

G. REFERRALS & LINKAGES

Delivery of a housing assistance program typically calls for flexibility and a menu of supportive services based on the needs of clients. The Housing Navigator will assist the client in obtaining additional needs identified, such as child support needs, independent living skills, and connecting to family and social support networks. Not only do the needs of the Ryan White eligible population vary and change over time, it is common to see co-occurring diagnoses that must be addressed. As a result, 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.

H. RE-ASSESSMENT OF HOUSING NEEDS

A re-assessment is a formal re-examination of the client'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 twelve (12) months and include:

- Review of client's clinical, financial and support needs to identify changes and/or additional services needs
- Summary of progress in achieving goals in the IHP, and any IHP revisions, as necessary

I. RE-CERTIFICATION (six months) REQUIREMENTS

To maintain eligibility for Ryan White services, the client (while active), must complete the sixth-month recertification process to verify the following information:

- Proof of residence
- Low income documentation
- Un-insured or under-insured status (Insurance verification as proof)
- Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare

Note: *At six month recertification one of the following is acceptable: full application and documentation, self-attestation of no change or self- attestation of change with documentation.*

J. PROCEDURE FOR MISSED APPOINTMENTS

- The client must be contacted within 2 days of missed appointment to determine if there was a reason why the appointment was not kept.
- The provider must attempt to reach the client no less than 2 times during a one-week period using the client-identified preferred contact method.
- Documentation of attempts to contact client must be noted in case file.

K. TRANSITION & DISCHARGE/CASE CLOSURE

Case Closure/Discharge

1. Reasonable efforts must be made to retain the client in services by phone, letter and/or any communication method agreed upon by the client. These efforts must be documented in the client's record.
2. The provider will make appropriate referrals and provide contacts for follow-up.
3. The provider must document date and reasons for closure of case including but not limited to:
    a. Attainment of goal(s)/service provided as planned
    b. Non-compliance with stipulations of written plan and client compliance agreement
    c. Change in status resulting in program ineligibility

d. Client termination request
e. No contact
f. Client moves out of service area
g. Client died

4. A summary of the services received by the client must be prepared for the client's record.

Case Transfer

1. If the client is being transitioned, the provider must facilitate the transfer of client records/information, when necessary.
2. The client must sign a consent to release of information form to transfer records which is specific and dated.

L. DOCUMENTATION

Documentation must be kept for each client, which includes:

1. Client's name and demographic information
2. Name and contact info of client's Medical Case Manager and Primary Care Provider, if they have one
3. Proof of HIV diagnosis.
4. Initial intake and needs assessment forms.
5. Signed, initial and updated individualized housing plan.
6. Consent for services.
7. Progress notes detailing each contact with or on behalf of the client. These notes must include date of contact and names of person providing the service.
8. Documentation that the client received rights and responsibilities information.
9. Signed "Consent to release information" form. This form must be specific and time limited.
10. Discharge and/or case closure information including person completing discharge and/or case closure, date and reason for discharge and/or case closure.

X. 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.

Housing Navigator or Case Manager

Minimum qualifications:

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 staff providing housing services:

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

All professional housing providers must complete the following 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 clients 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.