

THE EFFI BARRY TRAINING INSTITUTE

Housing Opportunities & Challenges for Persons Living with HIV

CASE MANAGEMENT OPERATING COMMITTEE
QUARTERLY TRAINING

April 18, 2019

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Effi Barry Training Institute Information

HIV/AIDS, HEPATITIS, STD AND TB ADMINISTRATION**COMPREHENSIVE CASE MANAGEMENT QUARTERLY TRAINING:
“HOUSING OPPORTUNITIES & CHALLENGES FOR PERSONS LIVING WITH HIV”*****Kellogg Center at Gallaudet University, Washington, DC****April 18, 2019***A G E N D A**

- 9:30 – 9:35am** Welcome & Introductions
Courtney Parson & Charles Brown, Co-chairs, CMOC
- 9:35 – 10:00 am** LinkU – The Online Resource Guide is Here!
Ashley Coleman, Program Officer, Ryan White Program, HAHSTA
- 10:00 – 11:00 am** HAHSTA’s Housing Services
Sherita Grant, Housing Coordinator and Baron Bell, Administrative Specialist, HAHSTA
- Overview of Housing Opportunities for People Living with AIDS & Housing Programs
 - HOPWA Service Area
 - Tenant-Based Rental Assistance (TBRA)
 - Short Term Rental Mortgage Utilities (STRMU)
 - Facility-Based Housing (Transitional & Emergency)
 - Housing Information Services
 - Permanent Housing Placement
 - Supportive Services
 - Case Management, Transportation, Food & Nutrition, Substance Abuse Counseling & Job Training
 - FY 18 Performance
 - FY 19 Goals
- Break 11:00 – 11:15 am**
- 11:15 am – 12:30 pm** Other HAHSTA Housing Programs
- Violence Against Women Act (VAWA)
 - Sharp
 - HITE
 - Bridges
 - Emergency Financial Assistance (EFA)
- 12:30 pm – 1:30 pm** **Lunch**
- 1:30 – 2:15 pm** Housing Counseling Services: Applications and Referrals
Renee Kelly & Oscar Mitchell, Housing Counseling Services
- EFA Applications
 - Referrals to other Housing Programs
- Break 2:15 – 2:30 pm**

2:30 – 4:15 pm “Panel Discussion: Housing Programs for Unique Populations”

Ashley Coleman, Facilitator, HAHSTA

- *Renee Kelly, Housing Counseling Services*
- *Kate Wiley, SOME - So Others Might Eat*
- *Jennifer Robles, District Alliance for Safe Housing (VAWA)*
- *Plathon Watson, Housing Coordinator, DC Office on Aging & Community Living*
- *Brandi V Gladden, Department of Behavioral Health*
- *Bentoya Curry, Senior Social Worker, Veteran’s Administration*

4:15 – 4:30 pm - Evaluations & Closing

Anita Jackson & Joanne Ocasio, Quality Assurance Committee Co-chairs, CMOC



In collaboration with the DC Case Management Operating Committee

DC | HEALTH
**HOUSING Opportunities & Challenges
for Persons Living With HIV**
Kellogg Center at Gallaudet University
April 18, 2019 – 9:30 a.m.-4:30 p.m.

DC GOVERNMENT OF THE
DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

**HOUSING OPPORTUNITIES & CHALLENGES FOR
PERSONS LIVING WITH HIV**
Welcome & Introductions



DC | HEALTH

**HOUSING OPPORTUNITIES AND CHALLENGES
FOR PERSONS LIVING WITH HIV**

AGENDA

- ❖ What Is HOPWA?
- ❖ HOPWA Service Area
- ❖ Total Number of Persons Living With HIV In HOPWA Service Area
- ❖ HOPWA Eligibility [Incomes and Activities]
- ❖ Last Year's HOPWA Housing Outcomes
- ❖ Federal Fiscal Year 2019 HOPWA Allocation & Goals
- ❖ Other Housing Programs for Persons Living With HIV In DC
- ❖ Lunch
- ❖ Working with Housing Counseling Services (HCS)
- ❖ Housing Resources for Unique Populations

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WHAT IS HOPWA?

Housing Opportunities for Persons With HIV/AIDS

❖ Cranston-Gonzalez National Affordable Housing Act 1992

❖ Purpose

– To provide States and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with acquired immunodeficiency syndrome and families of such persons.

❖ Housing Opportunity Through Modernization Act (HOTMA) of 2016

– Changed Formula From: Enumerated/Eligible Metropolitan Statistical Area (EMSA) with population of at least 500,000 and at least 1,500 Cumulative (included deceased) AIDS Cases

– To: EMSA with population of at least 500,000 and at least 2,000 people currently living with HIV

DC | HEALTH

HOPWA SERVICE AREA

Washington D.C.

DC | HEALTH

HOPWA SERVICE AREA

Maryland

❖ Prince George's County

❖ Calvert County

❖ Charles County

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HOPWA SERVICE AREA

Northern Virginia

- City of Alexandria
- Arlington County
- Clarke County
- Culpeper County
- Fairfax City
- Fairfax County
- City of Falls Church
- Fauquier County
- City of Fredericksburg
- Loudon County
- City of Manassas
- City of Manassas Park
- Prince William County
- Rappahannock County
- Spotsylvania County
- Stafford County
- Warren County

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HOPWA SERVICE AREA

West Virginia

- Jefferson County

DC HEALTH

HOPWA SERVICE AREA



DC HEALTH

TOTAL PERSONS LIVING WITH HIV IN SERVICE AREA

- Total--28,490 – As of 12-31-17 (Need updated Jefferson Co)
- District of Columbia (13,003)
- Balance Maryland (7,981)
 - ◊ Calvert County (114)
 - ◊ Charles County (449)
 - ◊ Prince George's (7,418)
- Balance Northern Virginia (7,506)
- Balance West Virginia (78)

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HOPWA INCOME ELIGIBILITY REQUIREMENTS

Must be 80% of Area Median Income (AMI)
For D.C. EMSA - Must be 50% of AMI

- Adjusted for Family Size
- Household Size of 1, up to \$41,050.00
- Household Size of 2, up to \$46,900.00
- Household Size of 3, up to \$52,750.00
- Household Size of 4, up to \$58,600.00
- Household Size of 5, up to \$63,300.00

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**HOUSING OPPORTUNITIES & CHALLENGES
FOR PERSONS LIVING WITH HIV**

HOPWA Services



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HOPWA ELIGIBLE ACTIVITIES/PRIORITY NEEDS

- Facility Based Housing (Operations & Development)
 - ◆ Short Term 60 Days within 6 Months
 - ◆ Transitional Housing – up to 24 Months
 - ◆ Permanent Housing

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HOPWA ELIGIBLE ACTIVITIES/PRIORITY NEEDS

- Short Term Facilities available in the EMSA
 - ◆ Community Family Life (18 SRO's)
 - ◆ Homes For Hope (12 1 bedroom units and 6 individual beds in shared housing)
 - ◆ Gaudenzia - Galber House (10 beds)
 - ◆ Gaudenzia - Walker Roberts (Emergency Housing -14 beds)

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HOPWA ELIGIBLE ACTIVITIES/PRIORITY NEEDS

- Permanent facilities available in the EMSA
 - ◆ Homestretch – Northern Virginia – (2 beds)
 - ◆ Jubilee – (5 beds)
 - ◆ Cornerstone (5 beds)

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HOPWA ELIGIBLE ACTIVITIES/PRIORITY NEEDS

- Tenant Based Rental Assistance (TBRA)
- Permanent Housing Placement (PHP)
- Short Term Rent Mortgage and Utility Assistance (STRMU)
- Housing Information
- Resource Development

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TENANT BASED RENTAL ASSISTANCE

- Provides housing at Fair Market Rate (FMR) FY2019
 - Efficiency - \$1,415
 - One-bedroom - \$1,454
 - Two-bedroom - \$1,665
 - Three-bedroom - \$2,176
 - Four-bedroom - \$2,678

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TENANT BASED RENTAL ASSISTANCE – CON'T

- Tenant Based Rental Assistance (TBRA)
 - ❖ Tenant pays 30% of adjusted gross income towards rent
 - ❖ Unit must meet Housing Quality Standards (HQS) Inspections
 - ❖ Current TBRA program has no set time limit

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TENANT BASED RENTAL ASSISTANCE – CON'T

- Tenant Based Rental Assistance (TBRA) Process
 - ◊ Case manager or client submits application to Housing Counseling Services (HCS)
 - Currently, there are no applications being accepted
 - ◊ Client is called from current eligibility list
 - ◊ Client must show proof of Housing Choice Voucher status
 - ◊ Client is assessed and issued a voucher from (HCS)
 - ◊ Client finds unit

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TENANT BASED RENTAL ASSISTANCE – CON'T

- Tenant Based Rental Assistance (TBRA) Process – Con't
 - ◊ Landlord accepts or rejects application
 - ◊ If landlord approves application, tenant submits approval letter to (HCS)
 - ◊ HCS reviews application to determine client's 30% portion of rent
 - ◊ HCS then forwards a moving packet to HAHSTA to pay the difference
 - ◊ HAHSTA adds client to TBRA payment roster
 - ◊ HAHSTA submits payment request to DCHA
 - ◊ DCHA submits payment to landlord within five (5) business days

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TENANT BASED RENTAL ASSISTANCE

- Currently, there are 378 clients on TBRA
 - ◊ If Clients currently have TBRA
 - HCS completes recertification forms.

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PERMANENT HOUSING PLACEMENT

- ❖ Pays for security deposits, background checks and application fees equaling up to two (2) months of rent
- ❖ HCS will determine if PHP is needed

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SHORT TERM, RENT, MORTGAGE & UTILITY ASSISTANCE – (STRMU)

- ❖ Assistance equaling 21 weeks within a 52 week period
 - Annual CAP is \$3,000 per fiscal year
- ❖ Assist client to remain stably housed in their own home or rental unit
- ❖ Assists client's with utility payments. Payments are made directly to the utility company.

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STRMU – CON'T

- (STRMU) – Process
 - ❖ Referral made to HCS
 - ❖ HCS reviews for approval/denial
 - ❖ HCS makes payment within two (2) business days

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HAHSTA FUNDED SUPPORTIVE SERVICES

- ❖ Part of TBRA and Facility Based Housing
 - Housing Case Management
 - Transportation
 - Meals and Nutrition
 - Substance abuse support

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SUPPORTIVE SERVICES – CON'T

- ❖ New Housing Model
 - Robust Supportive Services to assist clients in receiving job training and jobs to become stably housed and self sufficient without HOPWA assistance.

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FY 2018 HOPWA PERFORMANCE

- How Many Were Served
 - ❖ 509 PLWHA Obtained Rental Housing
 - ❖ 151 PLWHA Maintained Current Housing
 - ❖ 130 Homeless PLWHA Were Housed
 - ❖ 2 units to Expand Housing Stock Available to PLWHA
 - ❖ 722 PLWHA Being Self Sufficient
 - ❖ 9,183 PLWHA Received Housing Information

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FY 2018 HOPWA PERFORMANCE

— Beneficiary Profile

- ◆ 816 Qualifying persons assisted with housing
- ◆ 464 Other Family Members
- ◆ 482 Male Qualifiers
- ◆ 307 Female Qualifiers
- ◆ 27 Transgender Male to Female
- ◆ 694 Black
- ◆ 18 White
- ◆ 31 Other Multi-Racial
- ◆ 38 Hispanic

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FY2019 HOPWA OPERATING BUDGET

- Total 2019 Operating Budget--\$16,007,874
- Federal Fiscal Year 18 Allocation--\$11,221,025
- Reallocation From Prior Years --\$4,786,849

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FY 2019 HOPWA GOALS AND OBJECTIVES

- 2019 Funding Priorities
 - ◆\$9,287,413 Persons With HIV/AIDS Obtaining Rental Housing
 - ◆\$584,250 Persons With HIV/AIDS Maintaining Current Housing
 - ◆\$1,688,348 Persons With HIV/AIDS Being Self Sufficient
 - ◆\$543,210 Linking Persons With HIV/AIDS to Housing
 - ◆\$1,147,285 Housing Homeless Persons With HIV/AIDS
 - ◆\$2,500,000 units Expanding Housing Stock Available to Persons With HIV/AIDS

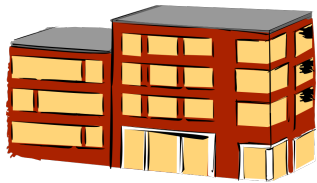
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HOPWA GOALS AND OBJECTIVES

- Target Goals of the DC EMSA HOPWA Program
 - ❖ 650 Persons With HIV/AIDS Obtaining Rental Housing
 - ❖ 250 Persons With HIV/AIDS Maintaining Current Housing
 - ❖ 500 Persons With HIV/AIDS Being Self Sufficient
 - ❖ 6,500 Linking Persons With HIV/AIDS to Housing
 - ❖ 140 Housing Homeless Persons With HIV/AIDS
 - ❖ 15 units Expanding Housing Stock Available to Persons With HIV/AIDS

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OTHER HOUSING PROGRAMS FOR PLWHA IN DC



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OTHER HOUSING PROGRAMS FOR PLWHA IN DC

Housing Independence Through Employment Program (HITE)

➤ GOAL

- Economic Independence
- Housing Independence

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OTHER HOUSING PROGRAMS FOR PLWHA IN DC

Housing Independence Through Employment Program (HITE)

➤ PROGRAM DESCRIPTION

- Financial support for housing and employment for up to 24 months
 - ✓ Participant pays 30% of income toward rent

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OTHER HOUSING PROGRAMS FOR PLWHA IN THE EMSA

Housing Independence Through Employment Program (HITE) – Con't

➤ ELIGIBILITY

- HIV+
- Resident of DC/MD/VA
- Single adult, single adult with a child, adult with a partner/husband households
- High school diploma or GED
- Work Eligibility
- Income at or below 500% Poverty line

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OTHER HOUSING PROGRAMS FOR PLWHA IN DC

Housing Independence Through Employment Program (HITE)

➤ ELIGIBILITY (CONTINUED)

- Identify realistic goals achievable within 24 months
- Mandatory Participation in Intensive Case Management
- Can demonstrate having within last 5 years 24 months of:
 - ❖ Full-time employment or part-time equivalent
 - ❖ Full time student
 - ❖ Part time student while working part or fulltime
 - ❖ Volunteer or Internships meeting full-time hours
 - ❖ Combination of any above

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OTHER HOUSING PROGRAMS FOR PLWHA IN DC

Sustainable Housing Assistance Rental Program (SHARP)

➤ PROGRAM DESCRIPTION

- Shallow rent subsidy
- 24 months, monthly flat rate rental assistance
- Severe rent burden (paying over 40% of income toward rent)
- Must be employed
- Must be able to demonstrate the affordability of unit

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OTHER HOUSING PROGRAMS FOR PLWHA IN THE EMSA

Sustainable Housing Assistance Rental Program (SHARP)

➤ ELIGIBILITY

- HIV+
- Resident of DC/MD/VA
- Rent must be greater than 40% of monthly income
- Not living in subsidized housing
- Case Management
- Ryan White income standards (\$60,150 for a single adult)

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OTHER HOUSING PROGRAMS FOR PLWHA IN DC

Sustainable Housing Assistance Rental Program (SHARP)

➤ GOAL

- Increasing housing stability
 - Reduce rent burdens
 - Address other barriers
- Improving health
- Incentivize household savings

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OTHER HOUSING PROGRAMS FOR PLWHA IN DC ONLY

Bridges Fund

PROGRAM DESCRIPTION

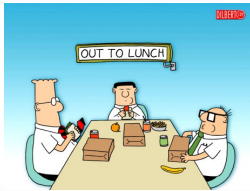
- ❖ The Bridges Fund is a "need based" program
- ❖ The Bridges Fund is designed to provide financial assistance to HIV+ individuals/families with rental delinquencies/situations
- ❖ Maximum assistance is \$2000 per fiscal year

TYPES OF ASSISTANCE

- ❖ First month's rent, security deposits, mortgage & utility delinquencies



HOUSING & OPPORTUNITIES AND CHALLENGES FOR PERSONS LIVING WITH HIV



ACCESSING SERVICES

Metropolitan Housing Access Program(MHAP)

HOUSING COUNSELING SERVICES, INC.

**METROPOLITAN HOUSING
ACCESS PROGRAM (MHAP)**

APRIL 18, 2019



ACCESSING SERVICES
Metropolitan Housing Access Program(MHAP)

- Housing Counseling Services, Inc. (HCS) is a non-profit housing counseling, training, and education agency.
- HCS has been providing comprehensive housing counseling services to the D.C. metropolitan region since 1972, helping clients respond to housing issues and accomplish housing goals.

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ACCESSING SERVICES
Metropolitan Housing Access Program(MHAP)

The D.C. Department of Health's HIV/AIDS, Hepatitis, STD, and TB Administration funds HCS to administer the Single Point of Entry for HOPWA housing and financial assistance program in the District of Columbia, Prince George's County MD, and Charles County, MD. The Single Point of Entry Program is named the Metropolitan Housing Access Program (MHAP).

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ACCESSING SERVICES
Metropolitan Housing Access Program(MHAP)

- Submit MHAP HOPWA Program Services Referral Form (starting May 1, 2019)
- Use referral form for STRMU/BRIDGES, HOPWA Housing, HIRS, HITE, and SHARP
- Upon receipt, MHAP staff will reach out to your client within 2 business days
- Do not use referral form for the Emergency Financial Assistance (EFA) Program!!

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ACCESSING SERVICES

MHAP HOPWA Program Services Referral Form
Submission

- Submit MHAP Referral Form via
- Email: mhap@housingetc.org
- Fax: 202-667-0862

- MHAP Referral Form/Process Questions:
- Jordan Kemmer 202-667-7568
- Sarcia Adkins 202-667-7567

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COMMON REASONS FOR DENIAL OF EFA APPLICATION

- Incomplete application/insufficient documentation
- Applicant has exhausted benefits for service area requested
- Applicant does not meet service area eligibility criteria
- EFA assistance will not completely resolve delinquency
- Applicant resides in subsidized housing

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COMMON REASONS FOR DENIAL OF EFA APPLICATION

- Insufficient housing plan (SMART - Specific, Measurable, Attainable, Relevant, Timely)
- EFA Referral Certification Form missing or not completed correctly

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EFA APPLICATION PROCESS

- >For applications that are complete and the household is determined eligible for requested EFA service(s), payment/voucher will be processed within 5 business days
- >For incomplete applications, the submitting case manager has 7 business days to submit required documentation. Failure to submit documentation will result in the denial and closure of the application.

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EFA APPLICATION PROCESS (CON'T)

- >Payments for rent, utility, telephone, moving, and medication will be mailed directly to vendor.
- >Food and hygiene vouchers must be picked up from HCS by the client or case manager within 7 business days of application approval. Failure to pick up vouchers within 7 business days may result in the release (denial) of the voucher.
- >Vouchers may be picked up from HCS on:
 - Monday and Tuesday 1pm – 4pm
 - Wednesday and Thursday 10am – 1pm

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EFA APPLICATION SUBMISSIONS

- >Email: efaprogram@housingetc.org
- >Fax: 202-667-0862

- >EFA Questions:
 - >Claudia Ramos 202-667-7564
 - >Sarcia Adkins 202-667-7567

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CONTACTING THE MHAP PROGRAM

Housing Counseling Services
MHAP Program
2410 17th Street, NW Suite 100
Washington, DC 20009

Phone- 202-667-2681
Fax- 202-667-0862
mhap@housingetc.org
www.housingetc.org

Oscar Mitchell (202) 667-7704
Renee Kelly (202) 667-7561



QUESTIONS FOR THE HOUSING TEAM

Anthony Fox, Division Chief
Anthony.fox@dc.gov

Sherita J. Grant, Housing Coordinator
Sherita.grant@dc.gov

Baron Bell, Administrative Specialist
Baron.bell@dc.gov

Monique Green, Housing Program Specialist
Monique.green2@dc.gov

202-671-4900





Housing Counseling Services, Inc.

Sustainable Housing Assistance Rental Program (SHARP)

Housing Independence Through Employment (HITE)

Metropolitan Housing Access Program (MHAP)

Program Brochure

Services Flyer

Program Referral Form (NEW)

The Sustainable Housing Assistance Rental Program is funded by the DC Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) and is administered by **Housing Counseling Services, Inc. (HCS)**

HCS is a non-profit 501(c) 3 organization founded in 1972 that provides comprehensive housing counseling, training, advocacy, technical assistance and housing opportunities for low- and moderate-income home buyers, home owners, and tenants; to help them achieve successful living in healthy, safe, and affordable homes.

The goal of HCS is to prevent homelessness and increase sustainable housing opportunities by providing the skills, self-esteem and empowerment necessary within families and communities. Further, HCS works to build the individual and group capacity for economic, physical, and social development of homes, neighborhoods, and communities.



Housing Counseling Services, Inc.

2410 17th St., N.W.
Suite 100 • Adams Alley
Washington, D.C. 20009
202-667-7006 •
www.housingetc.org



Housing Counseling Services, Inc.

Sustainable Housing Assistance Rental Program



Sustainable Housing Assistance Rental Program

The **Sustainable Housing Assistance Rental Program (SHARP)** provides temporary financial support with the goal of increasing housing stability and improving health for people living with HIV/AIDS.

SHARP provides eligible households with monthly flat rate rental assistance payments for up to 24 months. Monthly rental assistance will be equal to 40% of the current HUD Fair Market Rent values (see assistance guide for values.)

The program intends to reduce rent burdens, incentivize household savings, and address individual barriers to ensure future housing stability among participants.

Eligible households are those paying more than 40% of their income toward their rent.

Please note, SHARP participants will not be eligible for HOPWA or Ryan White emergency rental and utility assistance programs while in SHARP.

SHARP BASIC ELIGIBILITY CRITERIA:

- HIV+
- DC Eligible Metro Area Resident
- Must be employed
- Current rent must be greater than 40% of households monthly gross income.
- Not currently living in subsidized housing
- Willing to participate in case management
- Income at or below 500% of federal poverty line:

Income Guidelines: FY 2018

Household Size	Income
1	\$60,700
2	\$82,300
3	\$103,900
4	\$125,500
5	\$147,100
6	\$168,700

SHARP Assistance Guide

Unit Size	Monthly Assistance
Efficiency	\$566
1	\$581
2	\$666
3	\$870

TO APPLY:

- Complete and submit the SHARP Application with all supporting documentation. Application can be found on HCS's website at www.housingetc.org
- Select applicants will be invited to meet with an HCS case manager to further evaluate appropriateness.
- There are a limited number of openings and the application period will be closed once the program is filled. SHARP will not maintain a waiting list.

For more information please call: 202-667-2681

THE HITE PROGRAM is funded by the DC Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) and is administered by **Housing Counseling Services, Inc. (HCS)**

HCS is a non-profit 501(c) 3 organization founded in 1972 that provides comprehensive housing counseling, training, advocacy, technical assistance and housing opportunities for low- and moderate-income home buyers, home owners, and tenants; to help them achieve successful living in healthy, safe, and affordable homes.

The goal of HCS is to prevent homelessness and increase sustainable housing opportunities by providing the skills, self-esteem and empowerment necessary within families and communities. Further, HCS works to build the individual and group capacity for economic, physical, and social development of homes, neighborhoods, and communities.



Housing Counseling Services, Inc.

2410 17th St., N.W.
Suite 100 • Adams Alley
Washington, D.C. 20009
202-667-7006 •
www.housingetc.org



The Housing **INDEPENDENCE** Through Employment Program (HITE)



THE HOUSING INDEPENDENCE THROUGH EMPLOYMENT PROGRAM

HITE supports highly motivated individuals in seeking increased income and improved employment opportunities with the goal of achieving their highest level of economic and housing independence. The HITE Program provides individuals with financial support for housing and employment enhancements for up to 24 months.

HITE participants will pay 30% of their income toward rent while engaged in this program and may be eligible for financial assistance to support career enhancement opportunities. Participants must agree to take active steps to improve employment opportunities and to engage with in-depth case management.

Participants must demonstrate aptitude, interest and experience in employment that, within two years, can lead to housing independence.

HITE PROGRAM ELIGIBILITY CRITERIA:

- HIV+
- Only open to single individual adult households
- High school diploma or GED
- Eligible to work in the United States
- Income must be below 500% of federal poverty line:

FY 2018 Max HITE income	\$60,700 Annually
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- Must be able to identify realistic goals, achievable within a 24 month period, to achieve economic and housing independence.
- Must engage in intensive case management and/or other HCS supportive services up to 4x/month

- At least 24 months of one of the following within the last 5 years:
 - Full-time employment, or a combination of part-time employment hours equal to that of full-time employment;
 - Full-time student;
 - Part-time student with part or full-time employment;
 - Paid or unpaid volunteering or internships meeting full-time hours
 - Any combination of the above

TO APPLY:

- Complete the HITE Initial Application posted on HCS's website at www.housingetc.org
- Select applicants will be invited to meet with an HCS case manager to further evaluate appropriateness for HITE.
- There are a limited number of openings and the application period will be closed once the program is filled. HITE will not maintain a waiting list.

For more information please call: 202-667-2681



The MHAP Program

The Metropolitan Housing Access Program (MHAP) is the centralized entry point for housing services for individuals living with HIV/AIDS in the District of Columbia and in Prince George's County and Charles County in Maryland. Administered by Housing Counseling Services (HCS), MHAP is funded by the D.C. Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) - a sub-grantee of the U.S. Department of Housing and Urban Development's (HUD) Housing Opportunities for Persons Living with HIV/AIDS (HOPWA) Program.

MHAP offers eligible individuals a comprehensive program of housing services designed to support the short and long term housing needs of persons living with HIV/AIDS through quick access to wide ranging housing programs. Persons in need of services may access MHAP services directly through HCS or request a referral for services through community organizations serving persons living with HIV/AIDS.

In addition to MHAP services, HCS provides comprehensive housing services for all metropolitan area residents. HCS offers counseling, training and technical assistance for foreclosure prevention, emergency rental assistance, rental housing search, home purchase, homeownership, tenant rights and responsibilities, money management/credit, fair housing and more.



Income Eligibility Guidelines for MHAP Financial Assistance and Housing Programs (as of 04/18)

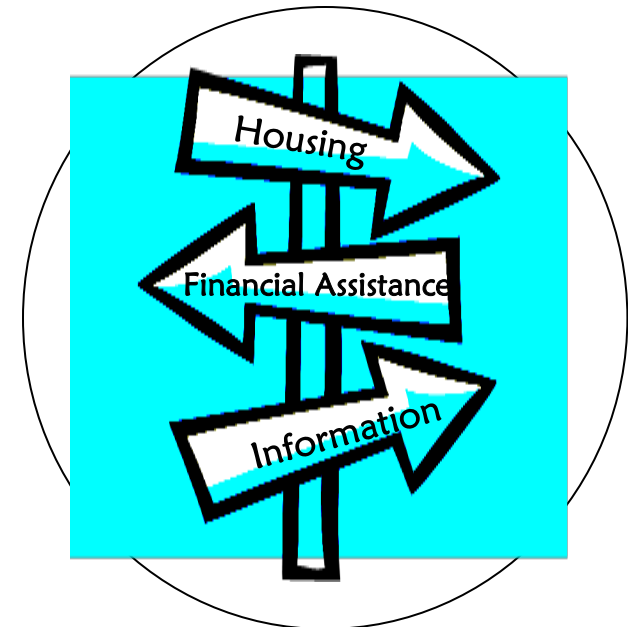
Household Size	Maximum Income
1	\$41,050
2	\$46,900
3	\$52,750
4	\$58,600
5	\$63,300
6	\$68,000
7	\$72,700
8	\$77,400

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

WE ARE WASHINGTON
GOVERNMENT OF THE
DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

Housing Counseling Services (HCS) is a HUD approved nonprofit 501(c)3 organization that provides comprehensive housing counseling, training and advocacy for low- and moderate-income tenants, homebuyers and homeowners. Our goal is to build sustainable communities through informed housing consumers. HCS is funded by the DC Department of Housing and Community Development, DC Department of Health HIV/AIDS, Hepatitis, STD and TB Administration, Enterprise Community Partners, US Department of Housing and Urban Development, US Department of Veteran Affairs, DC Department of Human Services, DC Housing Finance Agency, The Greater Washington Community Foundation, The Morris and Gwendolyn Cafritz Foundation, Capital One Bank, DC Department of Insurance Securities and Banking, DC Mayor's Office of Asian and Pacific Islander Affairs, DC Mayor's Office of Latino Affairs, The Share Fund, JP Morgan Chase Fund and your generous donations.

METROPOLITAN HOUSING ACCESS PROGRAM (MHAP) for PERSONS LIVING WITH HIV/AIDS



Housing Counseling Services

2410 17th Street, NW
Suite 100 Adams Alley
(between Euclid St. and Kalorama Rd.)
Washington, DC 20009
(202) 667-2681 or 1 (877) 459-7700
Fax (202) 667-0862
www.housingetc.org

What Housing Services Does MHAP Offer?



Financial Assistance.

Eligible households can receive short-term financial assistance towards their rental, mortgage, and utility delinquencies as well as a security deposit* and first month's rent*.



Long-Term and Temporary Housing Programs.

Subsidized housing programs*, transitional housing* and emergency housing* specifically for persons living with HIV/AIDS .



Housing Information and Referral Services (HIRS).

Receive personal assistance to respond to your current housing needs, as well as to help stabilize your long-term housing situation.

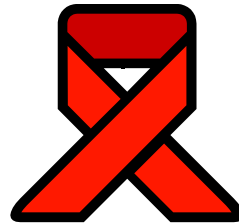
*D.C. residents only

Am I Eligible for MHAP Services?

To be eligible for MHAP housing and financial assistance programs your household must:

- ✓ Live in the District of Columbia, Prince George's County, MD or Charles County, MD**;
- ✓ Have at least one household member who is HIV+;
- ✓ Meet income eligibility guidelines for financial assistance or housing programs (*see back of brochure*).

**Charles County, MD residents can only receive HIRS



How Can I Apply for MHAP Services?

Applying for the MHAP housing or financial assistance program is as easy as ...

1. **Contact HCS at 202-667-2681 to schedule an appointment with a MHAP housing specialist.**
2. **Attend your scheduled application appointment.** Bring all required documentation to your appointment to ensure timely processing of your application
3. **Access services.** MHAP will process your application and help you respond to your important housing needs.



Housing Counseling Services, Inc.

METROPOLITAN HOUSING ACCESS PROGRAM (MHAP)

- *Are you HIV+?
- *Is your housing at risk or unstable?
- *Do you live in the District of Columbia or Prince George's County, MD?

If you answered YES to these questions, call MHAP for assistance!!

MHAP can be reached at 202-667-2681

and at MHAP@HOUSINGETC.ORG.

FINANCIAL ASSISTANCE

MHAP's STRMU Program can assist eligible households with:

- *Rent* -*Mortgage* -*Utility Bills*

MHAP's BRIDGES Program can assist eligible District of Columbia households with:

-*Security Deposits* -*First Months Rent*
-*Rent* -*Mortgage* -*Utility Bills*

HOUSING PROGRAMS

MHAP can connect eligible District of Columbia households to transitional and emergency housing programs specifically for persons living with HIV.

HOUSING INFORMATION AND REFERRAL SERVICES (HIRS)

Housing case management to help respond to housing barriers.

Referrals to housing programs, medical case management, and other support services.

Connection to HCS' full range of housing counseling and education services.

SUSTAINABLE HOUSING ASSISTANCE RENTAL PROGRAM (SHARP)

Provides a maximum 24 month rental subsidy to eligible employed households assessed as rent burdened. Monthly subsidies range from \$322-\$1,070.

SHARP offers case management services to support long term housing stability.

HOUSING INDEPENDENCE THROUGH EMPLOYMENT (HITE) PROGRAM

Provides a maximum 24 month rental subsidy for eligible individuals.

Financial assistance is available to support career advancement opportunities.

Requires participation in HITE's intensive employment and housing support services.

For more information, please visit HCS' website: www.housingetc.org



Housing Counseling Services, Inc.

2410 17th St., N.W. • Suite 100 • Adams Alley • Washington, D.C. 20009

202-667-7006 • www.housingetc.org

HOUSING COUNSELING SERVICES MHAP HOPWA PROGRAM SERVICES REFERRAL

Housing Counseling Services (HCS) Metropolitan Housing Access Program (MHAP) can assist eligible HIV+ clients access a variety of housing programs/services supported by HUD's Housing Opportunities for Persons Living with AIDS (HOPWA) funding. These services include housing related financial assistance, transitional/emergency housing, and housing information and referral services. Please complete the referral information below and submit this form to the HCS MHAP Program. Upon receipt, HCS MHAP staff will reach out to the referred client within two (2) business days to schedule an appointment to meet with a HCS staff person towards addressing their presenting housing issue.

TODAY'S DATE: _____

CLIENT NAME: _____

ADDRESS: _____ **APT #:** _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____ **EMAIL ADDRESS:** _____

My signature below authorizes my case manager (case manager's name) _____ to refer me to HCS for housing assistance. I also give permission to my case manager to release information to HCS regarding my protected health status.

Client Signature: _____ **Date:** _____

TYPE OF ASSISTANCE/PROGRAM REFERRAL IS FOR:

- STRMU (Financial Assistance for Rent, Mortgage, and Utilities)**
- TRANSITIONAL/EMERGENCY HOUSING**
- HOUSING INDEPENDENCE THROUGH EMPLOYMENT (HITE) PROGRAM**
- SUSTAINABLE HOUSING ASSISTANCE RENTAL PROGRAM (SHARP)**
- OTHER HOUSING ASSISTANCE (circle all that apply):**

Landlord/Tenant Issue

Housing Condition

Fair Housing

Mortgage Delinquency/
Foreclosure Counseling

Home Purchase Counseling/
Education

Credit Counseling/
Money Management

Other: _____

Additional relevant info (ex. client has writ, client is in shelter, etc): _____

CASE MANAGER SUBMITTING REFFERAL: _____

CASE MANAGER AGENCY: _____

CASE MANAGER TELEPHONE NUMBER: _____

CASE MANAGER'S EMAIL ADDRESS: _____

Please submit this referral form to HCS' MHAP Program via email at mhap@housingetc.org (Subject: MHAP Referral) or via fax at (202)-667-0862. For additional information regarding the HCS MHAP Program please contact HCS at (202) 667-2681.

Emergency Financial Assistance

Service Standards

Application

Homelessness Verification Form

Zero Income Affidavit

Referral Certification

Moving Assistance Inventory List

Client Rights and Responsibilities

Moving Assistance Client Terms

W-9 Form

SERVICE STANDARDS

FOR

EMERGENCY FINANCIAL ASSISTANCE (EFA)

Origination date: 2018	
Reviewed/Approved by the Care Strategies, Coordination and Standards (CSCS) Committee	1/10/18
Approved by the Planning Council	2/22/18



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 Emergency Financial Assistance (EFA) is to support persons living with HIV (PLWH) focus on their health (becoming or remaining virally suppressed) by temporarily providing assistance that addresses emergency needs and plans for longer-term solutions.

III. SERVICE DESCRIPTION

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist the client with an emergent need in paying for essential utilities, housing, food (including groceries and food vouchers), transportation, and medication. Emergency Financial Assistance can occur as a direct payment to an agency or through a voucher program.

Program Guidance:

Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

IV. TYPES OF ELIGIBLE SERVICES

Emergency Financial Assistance (EFA) activities are composed of the following eligible services:

1. Emergency rental assistance (first month's rent, past due rent);
2. Emergency utility payments (gas, electric, oil and water)
3. Emergency telephone services payments;
4. Emergency food vouchers;
5. Emergency hygiene vouchers;
6. Emergency moving assistance; and
7. Emergency medication

V. IMPLEMENTATION GUIDELINES

Emergency Financial Assistance (EFA) programs are intended to address emergency needs that could result in eviction for non-payment of rent, disconnection of utilities or telephone service, lack of sufficient food, or lack of hygiene products. Provision of EFA should be part of a larger plan to address barriers to HIV care and treatment. Therefore, EFA is a collaborative effort between case managers and EFA provider staff and all applications must be submitted by the client's case manager. Case management and EFA provider staff must ensure that they are familiar with these Service Standards and all other EFA related policies and procedures to ensure the effective implementation of EFA services. If a client (potential EFA applicant) does not have a case manager, the EFA provider staff will refer the client to an agency that provides access to case management services.

1. Application Tracking System: EFA provider agencies must develop, implement and maintain a comprehensive tracking system that documents a client's EFA application status from start to finish; i.e., incomplete draft, complete, submitted, pending, approved, denied, error, requested service provided, etc.
2. EFA provider agencies must establish frequent communication guidelines for staff to communicate application status at each stage with the case manager who submitted the application.
3. EFA provider agencies must also maintain effective methods of communication with other HIV providers in the jurisdiction to ensure that there is widespread knowledge and understanding of the EFA benefits available for clients.
4. Incomplete Applications: EFA provider staff must contact the case manager who submitted the application within 24 hours of receipt to convey the incomplete status. EFA provider staff and case managers must work together to ensure that the application is completed. If the application is incomplete over seven business days, the EFA provider agency can deny the application and the case manager must re-submit.
5. EFA provider agencies must develop policies, procedures and forms that reflect all requirements of the EFA Service Standards.
6. All agency staff providing EFA must undergo comprehensive training regarding the policies, procedures and documentation requirements.
7. Supervisor(s) must conduct quarterly audits of EFA client records to ensure that EFA applications are processed in accordance with agency policies and procedures, particularly the policies regarding eligibility, documentation, and timeliness of application processing.
8. Timeline for Processing EFA Application and Providing EFA: The emergency nature of this benefit requires that the application processing and the subsequent provision of the benefit be done in a timely manner, to avoid any harmful consequences brought on by the initial need. In jurisdictions where EFA is provided directly by case managers, completed EFA applications must be processed within three business days of receipt. In jurisdictions where EFA is provided centrally, completed EFA applications must be processed within five business days of receipt.
9. Clients that require receipt of a specific voucher must be notified of the availability of their approved voucher within 24 hours of its approval and arrangements for the expeditious provision of that voucher to the client must be made. If case managers are picking up vouchers on the client's behalf, it must be done within 24 hours of its approval.

VI. 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 of services and payments to verify that:

- EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the grantee
- Assistance is provided only for the following essential services: utilities, housing, food (including groceries, food vouchers, and food stamps), or medications
- Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients
- Emergency funds are allocated, tracked, and reported by type of assistance
- Ryan White is the payer of last resort

VII. 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.

VIII. 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.

IX. 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.

X. SERVICE DELIVERY COMPONENTS AND ACTIVITIES

A. INITIAL ELIGIBILITY DETERMINATION & ANNUAL RECERTIFICATION REQUIREMENTS

1. Proof of HIV diagnosis (Confirmatory HIV test [multi-spot, P24antigen, 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
12. Any other service-specific data.
13. Documented explanation about the services available within the provider agency and within the Ryan White Program.

C. FINANCIAL ASSESSMENT

The purpose of the Financial Assessment is to identify the client's severity of need for emergency financial assistance and therefore ensure that the most urgent needs are addressed prior to less urgent needs. The Financial Assessment may be performed concurrently with the client intake but must be done by the case management provider.

D. FINANCIAL PLAN

The Financial Plan is to ensure that the client applying for services will be able to achieve financial stability. The Financial Plan provides a structured, accountable approach by which the client may achieve a degree of stability so the EFA will not be required in the future. This plan must be feasible and created with the client by the case manager. The Financial Plan must be developed and documented in the client file as well as submitted with the EFA Application. The Financial Plan must be updated with each application for EFA.

The Financial Plan must include the following components:

1. Description of the emergency necessitating the need for financial assistance;
2. Identification of agreed upon client needs and individualized goals;
3. Identification of barriers;
4. Designated individuals who will perform each activity;
5. Timeline for each activity, with start and targeted end date; and
6. Date and signature by the client or their legal representative as well as the case manager or appropriate EFA provider staff member.

E. PRIORITIZATION

EFA is not meant to be a continuous means of support; rather, it is meant to be provided with limited frequency and for limited periods of time and is based on the availability of funds. To maintain this directive, the EFA provider must prioritize EFA applications based on the severity of need identified in the Financial Assessment. The prioritization process must be based on the following criteria, dependent on the type of financial assistance requested:

1. Health status;
2. Recent hospitalizations due to opportunistic infections or other sickness;
3. Homelessness or imminent risk of homelessness,
4. Families with dependent children;
5. Poverty; and
6. Other situations indicating urgent need.

F. MONITORING OF FINANCIAL PLAN

The Financial Plan is to ensure that the client applying for services will be able to achieve financial stability. The Financial Plan provides a structured, accountable approach by which the client may achieve a degree of stability so that hopefully, EFA will not be required in the future. The Financial Plan is monitored by the case manager.

G. REFERRALS & LINKAGES

Referrals & Linkages is a two-step process of connecting a client to appropriate services, whether within the same agency providing EFA or another agency, in order to support the client's successful completion of the goals and objectives in the Financial Plan. After the client is referred to the service, follow-up is necessary to ensure that the client makes a connection, or linkage, with the other service provider.

The purpose is two-fold: 1) to ensure that the client has multiple sources of assistance to address the emergency financial crisis and therefore contribute to stability and 2) to ensure that RWHAP funds are used as the payer of last resort.

H. REASSESSMENT OF FINANCIAL NEED

A reassessment of the client's financial need is required every time the client presents with an emergency need and desires to apply for EFA. This reassessment is to determine if additional EFA is needed and to monitor the progress of the client's previous Financial Plan.

During the reassessment, the case manager will:

1. Examine the client's progress (or lack thereof) toward achieving the goals and objectives described in the client's Financial Plan and
2. Determine if additional EFA is needed.

As part of this process, the case manager must follow-up on the client's linkage to referrals made during previous EFA applications, if this has not occurred already.

For clients in need of further assistance due to continuing emergency situations, the case manager will submit a new EFA application for the client.

EFA funds are limited, so it is essential that case managers reassess client's needs for these services at regular intervals. This reassessment will enable the case manager to determine any financial obstacles interfering with the client's stability and resulting ability to maintain or achieve viral load suppression.

I. RECERTIFICATION (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. Completed EFA Application with client's name, demographic info, and referring case manager's name and contact info. *(Case Manager and EFA provider's chart)*
2. Proof of HIV-positive status. *(Case Manager's chart)*
3. Initial Intake and Financial Assessment forms. *(Case Manager's chart)*
4. Signed, initial and updated Financial Plan. *(Case Manager and EFA provider's chart)*
5. Consent for services. *(Case Manager and EFA provider's chart)*
6. 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. *(Case Manager and EFA provider's chart)*
7. Documentation that the client received rights and responsibilities information. *(Case Manager and EFA provider's chart)*
8. Signed "Consent to release information" form. This form must be specific and time limited. *(Case Manager and EFA provider's chart)*
9. Discharge and/or case closure information including person completing discharge and/or case closure, date and reason for discharge and/or case closure. *(Case Manager and EFA provider's chart)*

XI. EFA SERVICE AREA REQUIREMENTS

1. Emergency Rental Assistance (first month's rent, past due rent)

Scope of Service	<ul style="list-style-type: none"> Provides emergency rental payments for applicants with critical delinquency, or first month's rent for new dwelling. The EFA provider makes payment directly to landlord. 																		
Additional Eligibility Criteria	<ul style="list-style-type: none"> Applicant must be at least one month past due to submit an application for delinquent rent unless a summons or writ of eviction has been received. Applicants whose past due balance exceeds the maximum benefit, must pay down to the benefit amount before a check can be issued to provide assistance. 																		
Required Documentation	<ul style="list-style-type: none"> Approval letter with monthly rent amount for first month's rent. Delinquency notice or itemized statement for emergency rent from landlord. A copy of a current lease agreement. A W-9 Form with the landlord's Tax Identification Number. The EFA provider is required to report all rental payments to the IRS each year. 																		
Maximum Benefit	<ul style="list-style-type: none"> Annual cap for rental assistance is based on Fair Market Rents (FMR) established by HUD. For applicants renting rooms, the annual cap for rental assistance will be based on an \$800 FMR. Applicant can receive assistance on multiple occasions in a 12 month period, as long as the total amount of assistance in the 12 month period does not exceed the equivalent of three times one month's rent at the fair market rate. 																		
<p>Final FY 2018 FMRs By Unit Bedrooms</p> <table border="1"> <thead> <tr> <th>Year</th> <th>Efficiency</th> <th>One-Bedroom</th> <th>Two-Bedroom</th> <th>Three-Bedroom</th> <th>Four-Bedroom</th> </tr> </thead> <tbody> <tr> <td>FY 2018 FMR</td> <td>\$1,504</td> <td>\$1,561</td> <td>\$1,793</td> <td>\$2,353</td> <td>\$2,902</td> </tr> <tr> <td>FY 2017 FMR</td> <td>\$1,440</td> <td>\$1,513</td> <td>\$1,746</td> <td>\$2,300</td> <td>\$2,855</td> </tr> </tbody> </table> <p>NOTE: This is a 50th Percentile Final FY 2018 FMR area as established by HUD regulations.</p>		Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom	FY 2018 FMR	\$1,504	\$1,561	\$1,793	\$2,353	\$2,902	FY 2017 FMR	\$1,440	\$1,513	\$1,746	\$2,300	\$2,855
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom														
FY 2018 FMR	\$1,504	\$1,561	\$1,793	\$2,353	\$2,902														
FY 2017 FMR	\$1,440	\$1,513	\$1,746	\$2,300	\$2,855														
Exclusions	<ul style="list-style-type: none"> Cannot make mortgage payments. Cannot pay security deposits. Residents of subsidized housing may not receive rental assistance unless assistance is requested to move to a new unit which is not subsidized. 																		

2. Emergency Utility Payments (gas, electric, oil and water)

Scope of Service	<ul style="list-style-type: none"> Provides payment of electric, water, or gas bills. The EFA provider makes payment directly to utility company.
Additional Eligibility Criteria	<ul style="list-style-type: none"> Applicant must have a disconnection notice to be eligible to apply. <i>Applicants whose past due balance exceeds the maximum benefit, must pay down to the benefit amount before a check can be issued to provide assistance.</i>
Required Documentation	<ul style="list-style-type: none"> Applicant must provide a copy of a bill that includes a disconnection notice. Bill must be dated within 30 days of the application date to ensure current billing information.
Maximum Benefit	<ul style="list-style-type: none"> Maximum benefit for a 12 month period is \$1500. Applicant can receive assistance on multiple occasions in a 12 month period, as long as the total amount of assistance in the 12 month period does not exceed \$1500.
Exclusions	<ul style="list-style-type: none"> Residents of subsidized housing are not eligible for utilities assistance.

3. Emergency Telephone Services Payments

Scope of Service	<ul style="list-style-type: none"> Provides for payment of telephone bills. The EFA provider makes payment directly to telephone company.
Additional Eligibility Criteria	<ul style="list-style-type: none"> Applicant must have a disconnection notice to be eligible to apply. <i>Applicants whose past due balance exceeds the maximum benefit, must pay down to the benefit amount before a check can be issue to provide assistance.</i>
Required Documentation	<ul style="list-style-type: none"> Applicant must provide a copy of a bill that includes a disconnection notice. Bill must be dated within 30 days of the application date to ensure current billing information.
Maximum Benefit	<ul style="list-style-type: none"> Maximum benefit for a 12 month period is \$300. Applicant can receive assistance on multiple occasions in a 12 month period, as long as the total amount of assistance in the 12 month period does not exceed \$300.
Exclusions	<ul style="list-style-type: none"> If telephone service is provided as part of a bundled package with other services such as cable TV or internet service, application and billing document must clearly identify the telephone charges that payment is requested for.

4. Emergency Food Vouchers

Scope of Service	<ul style="list-style-type: none"> Provides food vouchers in the form of supermarket gift cards. The EFA provider gives vouchers to case managers, who distribute the vouchers to applicants.
Additional Eligibility Criteria	<ul style="list-style-type: none"> Applicant must document effort to seek food resources elsewhere before accessing food vouchers.
Required Documentation	<ul style="list-style-type: none"> Documentation of effort to seek food from other resources is provided through a referral certification form, Applicants seeking food vouchers for dependents must provide proof of dependency through birth certificates, tax returns, or court documentation of guardianship. Vouchers are intended for food purchases only and shall not be used to purchase alcohol, tobacco products, or lottery tickets. Clients must sign a statement agreeing to the aforementioned policy.
Maximum Benefit- INDIVIDUAL	<ul style="list-style-type: none"> The maximum benefit for a single application for an individual is \$300. Applicants may access this service three times in each 12 month period, at intervals of at least three (3) months. Total 12 month cap for individual applicants is \$900.
Maximum Benefit – FAMILY	<ul style="list-style-type: none"> The maximum benefit for a single application for families is \$700. Family cap of \$700 is computed as follows: \$300 for the PLWH, plus \$100 per dependent for a maximum of four dependents. Applicants may access this service three times in each 12 month period, at intervals of at least three (3) months. Total 12 month cap for families is \$2100.
Exclusions	<ul style="list-style-type: none"> Dependents can only be included in a food voucher application if they are 18 or younger.

SPECIAL CRISIS \$25 FOOD VOUCHER PROGRAM

NOTE: Only to be used while awaiting approval on submitted Emergency Financial Assistance (EFA) and Supplemental Nutrition Assistance Program (SNAP) applications.

Emergency Food Voucher Program Rules

- This program does not replace the standard emergency financial assistance (EFA) food voucher program; rather, the two programs work together.
- Eligible participants are provided one \$25 food voucher (grocery store gift card) by their case manager while waiting for approval of their EFA food voucher and Supplemental Nutrition Assistance Program (SNAP) applications.
- The \$25 emergency food voucher will be subtracted from the final maximum food voucher allocation (or “cap”) for the client receiving the benefit.
- One emergency food voucher may be provided per client twice in each 12-month period, at intervals of at least 6 months apart.
- The EFA provider will distribute the \$25 emergency food vouchers to HAHSTA/Ryan White HIV/AIDS Program (RWHAP)-funded agencies with case management services according to the following formula based on the agencies’ number of Ryan White case management clients:
 - Agencies will receive one \$25 food voucher for each client up to five percent of clients.
 - Regardless of the number of clients, agencies will receive a minimum of five \$25 food vouchers.
 - Example: According to Agency X’s reports, it served 100 case management clients in grant year 24. In March 2015 (the beginning of the Ryan White Part A grant year), Agency X will receive \$125 in food vouchers (\$25 X 5 clients).
- The EFA application will contain a section where the case manager will report providing the emergency food voucher to the client, as well as attest that the client has submitted a SNAP application. The case manager MUST fill this section out and sign it, along with the client, so the EFA provider may track the provision of the food vouchers.
- Case managers providing emergency food vouchers must also keep a hard copy log of the emergency food vouchers provided, containing, at a minimum, the following information: client’s unique identifier, client’s date of birth, client’s gender, amount of voucher, barcode/serial number of voucher, and date provided. The log must be certified (signed) by a case management supervisor.
- When the emergency food voucher supply has been exhausted by the provider, the provider will provide a copy of the log in order to receive an additional supply in the same amount as the initial supply.
- HAHSTA will determine the amount of food vouchers to be distributed to RWHAP-funded agencies according to each agency’s number of medical case management clients served (see above).
- The EFA provider will notify agencies when the food vouchers are available for pick-up. Once the vouchers are picked up, the EFA provider will record receipt with the signature of the agency representative that received the vouchers.
- The page requiring signature will indicate that the receiving agency is responsible for storing the food vouchers in a secure location. Lost or stolen food vouchers will not be replenished.

Enrollment Process

- Clients must be eligible for the EFA food voucher program (see Eligibility section above).
- The case manager must submit an EFA application and verify that the SNAP application has been submitted by the client as well. A record of these submissions must be recorded in the client’s file.
- The client must indicate that he or she has an urgent need for food assistance.
- The case manager will provide the client with one \$25 food voucher (grocery store gift card).
- After supplying the emergency food voucher, the case manager must indicate that he or she has done so on the EFA application and record the voucher in the log (see above).
- The client will sign for receipt of the emergency food voucher.
- Case managers shall NOT provide an emergency food voucher without submitting an EFA application and a verifying with the client that a SNAP application has been submitted.

5. Emergency Hygiene Vouchers

Scope of Service	<ul style="list-style-type: none"> Provides hygiene vouchers in the form of pharmacy gift cards. The EFA provider will provide vouchers to case managers, who distribute the vouchers to applicants.
Additional Eligibility Criteria	<ul style="list-style-type: none"> No additional criteria
Required Documentation	<ul style="list-style-type: none"> Vouchers are intended for the purchase of personal hygiene items only and shall not be used to purchase food, alcohol, tobacco products, or lottery tickets. Clients must sign a statement agreeing to the aforementioned policy.
Maximum Benefit	<ul style="list-style-type: none"> The maximum benefit for a single application is \$75. Applicants may access this service three times (3) in a 12 month period, at intervals of at least four months. The maximum benefit during a 12 month period is \$225.
Exclusions	<ul style="list-style-type: none"> Only persons living with HIV (PLWH) are eligible for hygiene vouchers. Family members are not eligible.

6. Emergency Moving Assistance

Scope of Service	<ul style="list-style-type: none"> Provides payment of moving services for applicants that are moving to a new dwelling. <i>The EFA provider may obtain a contract with a moving company for no more than one year, or obtain quotes from various companies per job to obtain the most cost-effective service.</i>
Additional Eligibility Criteria	<ul style="list-style-type: none"> No additional criteria
Required Documentation	<ul style="list-style-type: none"> Inventory of items to be moved Addresses of pickup and delivery location; client name and contact info for applicant.
Maximum Benefit	<ul style="list-style-type: none"> Maximum benefit is \$2000. Service may be accessed once in a 12 month period.
Exclusions	<ul style="list-style-type: none"> <i>Service cannot be used to move applicant outside of the Eligible Metropolitan Area (EMA).</i>

7. Emergency Medication

Scope of Service	<p>EFA Medication provides:</p> <ul style="list-style-type: none"> HIV medications that are not included in the ADAP formulary Medications when the ADAP financial eligibility is restrictive Medications if there is a protracted State ADAP eligibility process (such as a wait list) and/or other means of accessing medications are not available (i.e., pharmaceutical company assistance programs) <p>Purchase of pharmaceuticals must be directly linked to the management of HIV disease that is:</p> <ul style="list-style-type: none"> Consistent with the most current HIV/AIDS Treatment Guidelines Coordinated with the State's Part B AIDS Drug Assistance Program (ADAP) Implemented in accordance with requirements of the 340B Drug Pricing Vendor Program and/or Alternative Methods Project
Additional Eligibility Criteria	<ul style="list-style-type: none"> Clients with insurance and other third-party payer sources are not eligible for EFA assistance unless there is documentation on file that the medication is not covered by their prescription benefits.
Maximum Benefit	<ul style="list-style-type: none"> Maximum benefit is \$4000. Service may be accessed no more than twice in a 12 month period. Any extenuating circumstances require recipient/administrative agent approval.

	<p>Purchasing Medications during ADAP application period No more than a 30 day supply of medication on the ADAP formulary can be purchased at a time for each client. If more than 30 days is needed, the medication can be refilled for another 30 days.</p> <p>-If the ADAP denied the coverage, the agency staff should work with the client and the client's attending physician to find alternate funding sources which may include manufacturer's compassionate /patient assistance programs, religious groups, or other community resources.</p>
	<p>EFA can be used during the ADAP eligibility determination period. Initial medications purchased for this use is not subject to the \$4000/client/year cap.</p> <p><i>EFA can be used to reimburse dispensing fees associated with purchased medications. Dispensing fees are not subject to the \$4000/client/year cap. Agency may reimburse the pharmacy a minimal dispensing fee per prescriptions as outlined in a MOU.</i></p>
<p>REGULATIONS</p>	<ul style="list-style-type: none"> • EFA medication must be purchased at the lowest possible cost, such as the HRSA 340B/Prime Vendor or Alternative Methods Project Program pricing. • Where possible clients need to obtain their medications through a 340B covered entity or pharmacy that is under contract with the 340B Program. • Another alternative for purchasing medication is to establish a cost reimbursement system with pharmacies licensed to distribute medications in the jurisdiction. • Contracts/Memorandums of Understanding (MOU) must be set up to purchase medications at wholesale or another below retail price. • Over-the-Counter medications to include vitamins may be purchased with EFA Medication funds if the medication is listed on the ADAP formulary and the provider has deemed that the medication is needed for prevention and treatment of opportunistic infections or to prevent the serious deterioration of health.

XII. 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.

EFA service staff must have a minimum of a high school diploma or general education development (GED) equivalent, and at least one year of client-related experience, one year of customer service experience, one year of administrative support experience; and/or have worked at least three years within a related health services field. Experience providing customer service and working with people in some capacity is a crucial requirement for all EFA service staff.

At minimum, all EFA service staff will be able to provide linguistically and culturally appropriate care for people living with HIV and complete documentation as required by their positions. EFA service staff will complete an agency-based orientation before providing services. EFA service staff will also be trained and oriented regarding client confidentiality, linguistic and cultural competency, stigma and Health Insurance and Accountability Act (HIPAA) regulations. EFA service staff must attend training on budgeting and money management skills, such as Consumer Credit Counseling.

HOUSING COUNSELING SERVICES
EMERGENCY FINANCIAL ASSISTANCE (EFA)
PROGRAM APPLICATION
DISTRICT OF COLUMBIA

Financial Assistance Application Information Sheet

Applicants may apply for Ryan White Emergency Financial Assistance (EFA) by completing this application with their case manager and submitting a completed application package to:

Housing Counseling Services, Inc.
Emergency Financial Assistance Program
2410 17th Street, N.W., Suite 100, Washington DC 20009
Tel: 202-667-2681 Fax: 202-667-0862
Email: efaprogram@housingetc.org

A completed application package will consist of the following documents:

- ❖ Emergency Financial Assistance Program Application: **All sections must be completed**
- ❖ Verification of HIV Status: Acceptable documentation include: physician's statement confirming HIV diagnosis; lab report detailing viral load counts (must be within the last 6 months); or confirmatory HIV test (multi-spot, P4antigen, or western-blot);
- ❖ Verification of District of Columbia (D.C.) Residency: Acceptable documentation include: current lease; current utility statement (dated within last 90 days); mortgage statement or deed settlement agreement; D.C. property tax bill/statement (dated within last 60 days); rent receipt verifying D.C. address (dated within last 90 days); valid D.C. driver's license/D.C. identification card; valid D.C. voter registration card; current notice of decision from D.C. Medicaid; paystub or bank statement verifying D.C. address; letter from government agency verifying D.C. address; unexpired homeowner/rental insurance policy; D.C. Healthcare Alliance Proof of Residency Form. **If homeless**, provide letter from service provider on agency letterhead or a completed homeless verification form.
- ❖ Documentation of all household income, including Public Assistance received, within the last 30 days. (if an adult household member has no income, he/she must submit a *Zero Income Affidavit*.)
- ❖ Picture ID for all adult (18 years or older) members of household
- ❖ Verification of all minor children (younger than 18) in household (acceptable documentation to demonstrate dependency include: birth certificate, court documentation, or tax return from most recent tax year)
- ❖ Completed and signed EFA Referral Certification Form for each EFA service category applicant is applying for (A Certification Form is not required for Moving Expenses and Emergency Medication service categories)
- ❖ Signed Consent to Release Medical Information Form (Page 12)
- ❖ Case manager submitting EFA Application must sign Page 12
- ❖ **See Section 4 of application for additional documentation that must be submitted for each service area the applicant is applying;**
- ❖ **Important: If determined eligible for first month's rent, delinquent rent, delinquent utility, delinquent telephone, or moving cost assistance, the applicant must provide documentation that any balance in excess of the EFA benefit amount authorized by HCS has been paid before HCS will issue payment to the vendor.**
- ❖ **The case manager's supervisor must review and sign this application on Page 12 (failure to sign, will result in immediate denial of the EFA application).**

Upon receipt of the application package, HCS will send the referring case manager a confirmation of receipt. **Failure to submit all required application documentation within 7 days of application submission will result in the denial of the financial assistance application. HCS may request additional documentation to verify eligibility and/or circumstances presented in the application.**

Section 1: Applicant Information

Date: _____ Unique ID: _____ Ward: _____

Applicant's Name: _____
Last Name First Name Middle

Current Address: _____
Street Apt. #

City State Zip Code

Length of time at this address: ____ years ____ months

Home Phone Cell Phone Email

Do you currently live in a unit that is supported by a federal, state, or local housing subsidy (includes Section 8, Public Housing, TBRA, and Shelter Plus Care)? ____ Yes ____ No
If yes, you may be ineligible for EFA rental and utility assistance.

Type of financial assistance you are applying for (select all that apply):

____ First Month's Rent ____ Past Due Rent ____ Utility Assistance
____ Moving Cost Assistance ____ Telephone Assistance ____ Food Voucher
____ Hygiene Voucher ____ Emergency Medication Assistance

Section 2: Applicant Demographic Information

1a. Gender: ____ Male ____ Female ____ Transgendered: MTF or FTM
(circle)

1b. Sex at birth: ____ Male ____ Female

2. Ethnicity: ____ Latino/Hispanic ____ Not Latino/Hispanic

If Hispanic, please choose all that apply: ____ Mexican, Mexican American/Chicano/a ____ Puerto Rican
____ Cuban ____ Other Hispanic, Latino/a, or Spanish origin (please describe) _____

3. Race: (Check only one)

Single Race

- American Indian/Native American (I) Black/African American (B)
- Native Hawaiian or Other Pacific Islander (PI) White (W)
- Asian Other

If Native Hawaiian or Other Pacific Islander, please choose all that apply:

- Native Hawaiian Guamanian or Chamorro
- Samoan Other Pacific Islander (please describe)

If Asian, please choose all that apply:

- Asian Indian (AI) Chinese (CH) Filipino (F) Japanese (JA)
- Korean (KR) Vietnamese (VT) Other Asian (please describe)

Or Multi-Race

- American Indian or Alaska Native and White (IW) Black/African American and White (BW)
- Asian and White (AW) American Indian/Alaska Native & Black /African American (IB)
- Other Multiple Race (O)

4. Language: Is English your primary language? Yes No If no, primary language: _____

5. Marital Status

- Single Married Separated Divorced Domestic Partnership

6. Current Housing Situation:

- Renter Live with Family/Friends Own Home Hospital/Rehabilitation Center
- Homeless, living on the street or in shelter/transitional housing Other _____

7. Is anyone in your household a U.S. military veteran (not including a reservist)? Yes No
If yes, provide the veteran's name(s) _____ Discharge Status: _____

8. Current Viral Load (within last six months): _____

9. Date of HIV Diagnosis: ____/____/____
MM DD YYYY

10. Do you currently have medical insurance? Yes (Insurance Provider _____) No

11. Date of last contact with health care provider: _____

12. Highest level of education completed: _____

13. Employment Training:

Have you participated in an employment training program within the last 12 months Yes No
If yes, did the employment training result in employment? Yes No

EMERGENCY CONTACT (Whom should the program call in case of emergency?)

Name: _____ **Relationship:** _____

Address: _____
Street Apt City State Zip

Phone Number: _____ **Email:** _____

Is the emergency contact aware of applicant's HIV status? Yes No

Section 3: Household Composition, Income, Expenses Information, and Financial Resources

HOUSEHOLD COMPOSITION & INCOME INFORMATION

Complete this section for all persons currently in household. Include all household income.

Does your household receive Food Stamps? Yes No If yes, provide the dollar amount: \$ _____

NAME	RELATION TO APPLICANT	DATE OF BIRTH & AGE	RACE*	SOCIAL SECURITY NUMBER	HIV POSITIVE (Y or N)	MONTHLY GROSS INCOME	ANNUAL GROSS INCOME	SOURCES OF INCOME (Work, SSDI, TANF, Child Support, etc.)
1.	Applicant							
2.								
3.								
4.								
5.								
Please submit additional form to list other household members.						Total	Total	

* For race, use abbreviations in parenthesis for responses to Question 3 on Page 3

HOUSEHOLD EXPENSES INFORMATION

Enter expected expenses for next month for applicant's household. This information will be used to help determine applicant's need for financial assistance. If applicant does not pay toward the expense category, please enter "0"

Expense	Amount	Expense	Amount	Expense	Amount
Rent/Mortgage		Car Loan		Education	
Electric		Car Insurance		Entertainment	
Gas/Oil		Car Repairs		Household Items	
Phone		Other Transportation Costs		Loan(s)	
Water/Sewer		Child Care		Personal Care	
Food		Child Support		Other	
Insurance Medical/Life		Laundry		Other	
Doctor/Dentist		Clothing		Other	
Medication		Credit Card(s)		Total Expenses	

Section 4: Financial Assistance Request

The maximum benefit an applicant can receive, during a 12 month period, for the Emergency Rental Assistance service area is three times (3X) one month's Fair Market Rent based on unit size.

Unit Size	Room	Eff.	1BR	2BR	3BR	4BR
2019 FMR (effective 10/01/2018)	\$800	\$1415	\$1454	\$1665	\$2176	\$2676

If requesting Emergency Rental Assistance for First Month's Rent, complete this section

Note: Residents of subsidized housing are ineligible for first month's rent assistance unless moving to a unit that will not be subsidized.

Name of Landlord/Management Company

\$ _____
Total Monthly Rent for Unit

\$ _____
First Month's Rent Assistance Requested

Lease Start Date

of bedrooms in unit

Landlord/Management Company Payment Address:

City/State/Zip

Landlord Telephone Number

ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:

- 1. Copy of approval letter from landlord;**
- 2. Copy of proposed lease;**
- 3. Federal W-9 Form completed and signed by landlord**

If requesting Emergency Rental Assistance for Past Due Rent, complete this section

Note: Applicant's rent must be at least one month delinquent to be eligible for Past Due Rent assistance. Applicants residing in subsidized housing are ineligible for past due rent assistance.

Name of Landlord/Management Company

Payment Address:

City/State/Zip

Telephone

Type of rental property:
 Single Family Home
 Apartment/Condo
 Room rental
 Other _____

of bedrooms in your unit _____

\$ _____
Regular Monthly Payment

\$ _____
Total Rent Past Due

(MM/DD-MM/DD)

Timeframe for delinquency

Have you received a writ or any court documents regarding this delinquency? Yes No

ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:

- 1. Itemized statement from landlord detailing delinquent rent and fees;**
- 2. Copy of current lease;**
- 3. If applicant is involved in D.C. Landlord Tenant Court proceedings, copies of all court related documents**
- 4. Federal W-9 Form completed and signed by landlord**

If requesting Emergency Utility Payment Assistance, complete the appropriate section below. The maximum benefit an applicant can receive, during a 12 month period, for the Emergency Utility Payments service area is \$1500. Applicants residing in subsidized housing are ineligible for Emergency Utility Payment Assistance.

<p>_____</p> <p>Electric Company Name</p> <p>_____ \$ _____</p> <p>Account Number Amount Due</p> <p>_____ Disconnect Notice?</p> <p>(MM/DD-MM/DD) ___ Yes ___ No</p> <p>Timeframe for delinquency</p>	<p>_____</p> <p>Vender Payment Address:</p> <p>_____</p> <p>Vender City/State/Zip</p> <p>_____</p> <p>Vender Telephone Number</p> <p>ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:</p> <ol style="list-style-type: none"> 1. Copy of disconnect notice from electric company; 2. Copy of most recent electric bill (must be dated within past 30 days)
<p>_____</p> <p>Gas/Oil Company Name</p> <p>_____ \$ _____</p> <p>Account Number Amount Due</p> <p>_____ Disconnect Notice?</p> <p>(MM/DD-MM/DD) ___ Yes ___ No</p> <p>Timeframe for delinquency</p>	<p>_____</p> <p>Vender Payment Address:</p> <p>_____</p> <p>Vender City/State/Zip</p> <p>_____</p> <p>Vender Telephone Number</p> <p>ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:</p> <ol style="list-style-type: none"> 1. Copy of disconnect notice from gas/oil company; 2. Copy of most recent gas/oil bill (must be dated within past 30 days)
<p>_____</p> <p>Water Company Name</p> <p>_____ \$ _____</p> <p>Account Number Amount Due</p> <p>_____ Disconnect Notice?</p> <p>(MM/DD-MM/DD) ___ Yes ___ No</p> <p>Timeframe for delinquency</p>	<p>_____</p> <p>Vender Payment Address:</p> <p>_____</p> <p>Vender City/State/Zip</p> <p>_____</p> <p>Vender Telephone Number</p> <p>ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:</p> <ol style="list-style-type: none"> 1. Copy of disconnect notice from water company; 2. Copy of most recent water bill (must be within past 30 days)

If requesting Emergency Telephone Service Payment assistance, complete this section. The maximum benefit an applicant can receive, during a 12 month period, for the Emergency Telephone Service Payments service area is \$300.

<p>_____</p> <p>Telephone Company Name</p> <p>Is this a cell/mobile phone? ___ Yes ___ No</p> <p>_____ \$ _____</p> <p>Account Number Amount Due</p> <p>_____ Disconnect Notice?</p> <p>(MM/DD-MM/DD) ___ Yes ___ No</p> <p>Timeframe for delinquency</p>	<p>_____</p> <p>Vender Payment Address:</p> <p>_____</p> <p>Vender City/State/Zip</p> <p>_____</p> <p>Vender Telephone Number</p> <p>ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:</p> <ol style="list-style-type: none"> 1. Copy of disconnect notice from telephone service provider; 2. Copy of most recent telephone bill (must be dated within past 30 days; the bill must be itemized detailing all charges). EFA can only cover telephone service charges.
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If requesting Emergency Moving Assistance, complete this section. The maximum benefit an applicant can receive, during a 12 month period, for the Emergency Moving service area is \$2000. Move must be within D.C. Eligible Metropolitan Area. This service may only be accessed once in a 12 month period.

<p>_____</p> <p>Moving Company Name</p> <p>_____</p> <p>Street Address Moving From</p> <p>_____</p> <p>City/State/Zip Moving From</p> <p>Number of bedrooms in unit: _____</p> <p>_____</p> <p>Street Address Moving To</p> <p>_____</p> <p>City/State/Zip Moving To</p> <p>_____</p> <p>Proposed Date of Move (mm/dd/yyyy)</p> <p>\$ _____ \$ _____</p> <p>Total Cost of Move Amount of Assistance Requested</p> <p>Explain reason for moving: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>Vender Contact Person</p> <p>_____</p> <p>Vender Payment Address:</p> <p>_____</p> <p>Vender City/State/Zip</p> <p>_____</p> <p>Vender Telephone Number</p> <p>ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:</p> <ol style="list-style-type: none"> 1. EFA Moving Cost Assistance Terms signed by applicant and submitting case manager. 2. Copy of moving company's written proposal to provide moving service. Estimate must be dated within 15 days of application submission. 3. Completed EFA Moving Assistance Inventory List. 4. Copy of moving company's business license and documentation of moving company meeting minimum EFA cargo, liability, and worker's comp. insurance requirements.
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**If requesting an Emergency Food Voucher, an Emergency Hygiene Voucher or
Emergency Medication, complete this section**

Category	Additional criteria/requirements
<p>Amount of <u>Emergency Food Voucher Assistance</u> requested: \$ _____</p> <p>The maximum benefit per application is \$300 for an individual and \$700 for a family with children dependents (\$100 per dependent – max. 4 dependents). The 12 month benefit cap for individuals is \$900 and for families is \$2100. Applicants may access this benefit three times (3X) in a 12 month period, at intervals of at least 3 months.</p> <p>Has the applicant applied for SNAP? ___ Yes ___ No</p> <p>Has this household received a Special Crisis \$25 Food Voucher while waiting a determination on this application? ___ Yes ___ No</p>	<p>ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:</p> <p>1. Applicant must sign Emergency Food Voucher/Emergency Hygiene Voucher Utilization Statement (page 12)</p>
<p>Amount of <u>Emergency Hygiene Voucher Assistance</u> requested: \$ _____</p> <p>Maximum benefit per application is \$75. The 12 month benefit cap is \$225.</p> <p>Applicants may access this benefit three times (3X) in a 12 month period, at intervals of at least 4 months.</p>	<p>ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:</p> <p>1. Applicant must sign Emergency Food Voucher/Emergency Hygiene Voucher Utilization Statement (page 12)</p>
<p>Emergency Medication Assistance</p> <p>What medications is applicant requesting assistance to purchase? _____</p> <p>Is this medication for the treatment of HIV? ___ Yes ___ No</p> <p>Does applicant currently have medical insurance? ___ Yes ___ No</p> <p>If no, has the applicant applied for Medicaid, Medicare, ADAP, HIAP, or CHIP? ___ Yes ___ No</p> <p>If yes, what was the result of their application? _____ _____</p> <p>Maximum assistance is \$4000 per year and is only for medications not included in ADAP formulary. Applicants may access this benefit no more than two times (2X) in a 12 month period.</p>	<p>ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:</p> <ol style="list-style-type: none"> 1. Verification of uninsured status <u>or</u> for applicants who have insurance and/or other 3rd party payer sources, submit documentation that the requested medication is not covered by their provider; 2. Copy of medication prescription 3. Confirmation from medical professional that medication is for treatment of applicant’s HIV <p>**Additional criteria apply to this category. Please contact HCS EFA staff to discuss circumstances of this request.</p>

**Section 5: Explanation of Financial Assistance Need and
Housing Stability Plan**

EXPLANATION OF FINANCIAL ASSISTANCE NEED

Please explain in detail the circumstances that caused the applicant's need for Emergency Financial Assistance. Use additional pages if necessary.

Please explain how EFA assistance will resolve the immediate emergency.

HOUSING/FINANCIAL STABILITY PLAN

Please identify barriers the applicant is experiencing that caused their financial need. Also, explain the specific steps the applicant, their household, and the case manager will take towards stabilizing your financial situation to prevent the need for future financial assistance. Please be specific and provide details in the plan. For example, “Applicant will look for employment” is not sufficient detail, however “Applicant will submit a minimum of 10 employment applications each week” provides greater detail. (attach additional pages if necessary).

Barrier(s) to Housing Stability	Activity to Overcome Barrier(s)	Date to Start Activity	Date to Complete Activity	Person Responsible for Completing Tasks
Example: Loss of Employment	1. Apply for unemployment benefits;	1. 02/01/18	1. 02/02/18	Applicant
	2. Refer applicant to DC Office of Employment Services and Temporary Employment Agencies	2. 02/10/18	2. Ongoing	Case Manager
	3. Applicant will apply to at least 10 employment applications per week.	3. 02/10/18	3. Ongoing	Applicant
1.				
2.				
3.				
4.				

Would the applicant like to meet with a Housing Counseling Services Case Manager for additional assistance developing a plan to stabilize their housing and/or financial circumstances?

Yes No

Section 6: Disclosures and Authorizations

Disclosure Statement

I understand that Housing Counseling Services, Inc. (HCS) may need to contact individuals and/or agencies (including but not limited to landlords/property management companies, mortgage companies, utility companies, telephone companies, employers, government agencies, medical/support service providers, pharmacies, and attorneys) to acquire information and verify eligibility for its programs and to maintain contact with me. My signature serves as my consent for HCS to contact individuals, businesses, and/or service provider(s) necessary to document my eligibility and my need.

Further, as a participant in a program funded by the local and federal government, I understand that annual audits will be conducted to verify HCS' compliance with local and federal regulations. I authorize HCS to allow the review of my personal program file, including all verifications and documentation, by the HCS Organizational Auditor or Funding Agency Compliance Auditor/Monitor. All Auditors/Monitors are prohibited from disclosing any personal client information to any source. This authorization will remain in effect as long as an Organizational Auditor or Compliance Auditor/Monitor determines that the review of client files is necessary to complete federally mandated audits, reviews and report(s). I also acknowledge that I have received Housing Counseling Services Client Rights and Responsibilities Form.

My consent is subject to revocation in writing by me at any time. This form has been read by me or to me prior to my signing it.

Applicant Signature:

Case Manager Signature:

Date:

Date:

Authorization of Representation/Release of Information/Consent for Services

The applicant authorizes that _____ (name of case manager) is permitted to represent the applicant in the process of applying to this financial assistance program and has permission to release information and receive information (including protected health information) related to all matters concerning the applicant in the process. The applicant also authorizes Housing Counseling Services (HCS) to release information (including HIV status and other protected health information) to housing and service providers operating within the HOPWA Housing System, Ryan White Services System, and to the D.C. Department of Health. This release may be revoked at any time verbally or in writing. The applicant understands that HCS will evaluate the application to determine eligibility for services available under the Emergency Financial Assistance Program Standards for the District of Columbia. HCS may need to speak with the applicant, case manager, or other parties to verify information contained within this application. My signature below confirms my consent for HCS to conduct activities necessary to fully evaluate my application. I also understand that HCS, upon review of my financial assistance application, may request that I meet with a housing counselor to discuss my housing stability or to discuss concerns regarding the circumstances of my financial assistance request. To the best of my knowledge and belief, I certify that the foregoing information is true, complete and accurate. I understand that if I have provided any false information, this may result in the denial of my application and may result in further investigation involving any intention to misuse government funds.

As an applicant I also understand that information I provide during the application process may be entered into CAREWare, which is an electronic health and social support services information system for Ryan White HIV/AIDS Program grant recipients and their providers. I understand that HCS staff may need to speak with me to collect additional information about my household for entry into CAREWare. I understand that failure to provide information requested by HCS for CAREWare may be grounds for the denial and closure of my application for housing assistance.

EFA Food/Hygiene Voucher Agreement Statement

I understand that if I have applied for and are approved for the Ryan White Emergency Financial Assistance (EFA) food and/or hygiene voucher, I acknowledge that this voucher is intended for personal expenses related to my well-being and shall not be used to purchase alcohol, tobacco products, lottery tickets, etc. Furthermore, I will not bargain, trade, nor exchange this card for other monetary value, products, and or services.

Applicant's Signature: _____ Date: _____

Application completed by (Case manager name): _____

Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Case Manager's Signature: _____

Date: _____

By signing this application, the case manager confirms that this application was completed at the request of the applicant and in the presence of the applicant.

As this case manager's supervisor, I attest that I have reviewed this application for financial assistance. I support this application and the completed Housing/Financial Stability Plan to overcome this temporary housing or financial emergency.

Case Manager Supervisor Name: _____

Supervisor Signature: _____

Date: _____ Phone Number: _____

EMERGENCY FINANCIAL ASSISTANCE (EFA) PROGRAM HOMELESSNESS VERIFICATION FORM

Applicant's Name: _____

Please check the applicant's current homelessness status and provide the appropriate verifying documentation:

Current Homeless Status	Attached Documentation
<input type="checkbox"/> An individual living in a homeless shelter	Written certification from a shelter social worker/case manager/outreach worker on agency letterhead.
<input type="checkbox"/> An individual living in a transitional housing program for homeless persons	Written certification from the agency social worker/case manager to include applicant's homeless status before program entry.
<input type="checkbox"/> An individual living on the street or places not meant for human habitation	Written verification from an outreach worker/case manager certifying that the applicant is homeless.
<input type="checkbox"/> An individual being discharged from a longer stay in an institution (ex: mental health hospital, halfway house, substance abuse treatment program)	Written documentation from the institution verifying that the applicant will be homeless within one week of his/her discharge date and the reason applicant will be homeless; and an explanation of efforts made to obtain housing,

I confirm that I meet one of the homelessness definitions above. I understand that I must also submit the appropriate documentation to verify my homelessness status.

Applicant's Signature: _____ Date: _____

**Housing Counseling Services
Emergency Financial Assistance Program
Zero Income Affidavit**

Name: _____ Date: _____

Address: _____

This statement is to certify that I am not receiving income from any source whatsoever:

- ❖ I am not employed through any private or public employer.
- ❖ I am not receiving unemployment or disability compensation, worker's compensation or severance pay.
- ❖ I am not receiving net income from the operation of a business or from rental or real personal property.
- ❖ I am not receiving interest, dividends and other net income of any kind for real personal property.
- ❖ I am not receiving alimony or child support payments (whether through the court system or not)
- ❖ I am not receiving regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling).
- ❖ I am not receiving periodic payments from Social Security benefits, any type of annuity benefits, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts.
- ❖ I am not receiving Public Assistance (PA) payments.
- ❖ I am not receiving regular monetary gifts from family and/or friends.
- ❖ I am not receiving income from any source.
- ❖ I am on maternity leave without pay __ (If so, please check).
- ❖ I am on sick leave without pay __ (If so, please check).

I have stated during this verification process that I have no income at this time. I have not received income since _____.

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify my household from participation in the MHAP program, and may be grounds for termination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. 3801-3812.

I certify that the above information is true and correct. I also understand that it is my responsibility to immediately report all changes to my household composition or income.

Signature

Date

Emergency Financial Assistance (EFA) Program Referral Certification Form

It is expected that all other sources of funding in the community for financial assistance will be used prior to accessing Ryan White Emergency Financial Assistance. **Applicants and case managers must complete this EFA Program Referral Certification Form for each Ryan White Emergency Financial Assistance service area (excluding Moving Assistance and Emergency Medication Assistance service categories) in which they apply to verify efforts to access other community resources.**

Applicant's Name _____ Today's Date _____

I, _____ confirm that the above named
Referring Case Manager's Name

applicant was referred to _____
Agency's Name

for _____ on _____. The result of the
Service Referred For **Date**

referral was: _____

If applying for Emergency Food Voucher assistance, has the applicant recently applied for the Supplemental Nutrition Assistance Program (SNAP)? Yes No

If yes, date of SNAP Application: _____

If yes, result of SNAP Application (circle): Approved Pending Denied

Case Manager Signature

Date

Case Manager Agency

My signature below confirms that the above information is accurate.

Applicant's Signature

Date

EMERGENCY FINANCIAL ASSISTANCE PROGRAM

Moving Assistance Inventory List

Applicant's Name: _____

Type of Unit Moving From: Single Family Home Townhome/Rowhome Apartment/Condo
(Circle)

Number of Bedrooms in Unit You are Moving From: _____

Estimated Number of Boxes to Be Moved: _____

Furniture/Miscellaneous Items	Furniture/Miscellaneous Items

Applicant Signature: _____ Date: _____



Housing Counseling Services, Inc.

2410 17th St., N.W. • Suite 100 • Adams Alley • Washington, D.C. 20009

202-667-7006 • www.housingetc.org

HCS Client Rights and Responsibilities

Housing Counseling Services, Inc. supports the rights of the client to express their concerns and opinions, actions and choices, and strives to ensure that each client is given respect, consideration, privacy and encouraged to participate in the development of their housing plans to achieve their housing, financial, and/or educational goals. These rights include the following:

- The right to services, regardless of race, ethnicity, language, religious belief, sexual orientation, gender, age, marital status, health status, disability, and source of income
- The right to services delivered in a culturally competent manner
- The right to services without the threat of physical, sexual, psychological, and fiduciary harassment/abuse
- The right to information about the organization, its funders, and its services
- The right to access services easily and in a timely manner
- The right to be informed of available services/resources (ex. legal, financial, and mental health services) to address their current/future housing related needs
- The right to have the confidentiality of their client files maintained. Only where compelling ethical, moral or legal reasons (ex. child protection legislation) will information be shared.
- The right to freely file a grievance, complaint, or appeal without retaliation

Housing Counseling Services' clients have the following responsibilities in accessing services:

- The responsibility to treat HCS staff, volunteers, and other HCS clients with dignity and respect
- The responsibility to provide HCS staff with true and accurate information to ensure that the best possible service is provided
- The responsibility to assist in the development and participation in an agreed-upon service/housing plan to address their housing related need(s)
- The responsibility to keep their scheduled appointments and to ensure prompt arrival. Clients should also provide timely notification of an appointment cancellation.
- The responsibility to inform HCS of any changes in their contact information (name, address, phone, etc.)
- The responsibility to report any concerns about the delivery of HCS services, possible fraud or abuse



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EMERGENCY FINANCIAL ASSISTANCE PROGRAM

MOVING COST ASSISTANCE TERMS

You are submitting an application for Moving Cost Assistance through the District of Columbia Emergency Assistance (EFA) Program administered by Housing Counseling Services (HCS). As an applicant for financial assistance, please be aware of the following terms and expectations:

- **HCS is not party to any contract between you and the moving company you select to perform your move. HCS is not responsible for any actions of your mover or for the loss or damage of any possessions.** If approved for EFA Moving Assistance, HCS will ONLY be providing financial assistance towards your moving expenses;
- You are responsible for selecting your own mover. We encourage you to take appropriate precautions by carefully researching the mover you select and details about how to protect yourself and your belongings during the move. HCS also encourages you to obtain and compare moving bids from at least three qualified movers;
- You must select a mover that provides appropriate levels of insurance to perform moving related services. Minimum required insurance levels for the EFA Moving Cost Assistance Program are:

Cargo
\$100,000

Comprehensive Liability
\$1,000,000

Worker's Comp
Per Local Statute

- For HCS to provide financial assistance payment on your behalf, the moving company must agree to HCS EFA payment procedures;
- You are responsible for resolving any problems/issues/disputes that arise during the move with the moving company. Prior to choosing your moving company, make sure you fully understand the contract you are entering into including their damage claims process, payment terms and requirements, and dispute resolution process;
- If you believe that your moving company acted inappropriately during your move, please contact your case manager immediately so that he/she can advise you as to what steps you may take to resolve your concerns. As HCS is not a party to the moving contract, we will not be able to act on your behalf to resolve your concerns with your mover.
- The maximum financial assistance available for moving cost assistance through the Emergency Financial Assistance Program is \$2000. Any costs above \$2000 is solely your responsibility. It is recommended that you have funds available on the day of the move in the event that the cost of your move exceeds \$2000. Failure to pay moving costs above \$2000 may result in the moving company not releasing your belongings on the day of the move and additional charges accruing. Most moving companies require payment in the form of cash, certified funds, or credit card.
- You must submit final invoice from the moving company to HCS within seven (7) business days of the completion of your move. Failure to provide this invoice may result in HCS being unable to pay any additional expenses on your behalf;



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- If the final cost of your move exceeds the initial payment made by HCS, HCS will only issue an additional payment upon receipt of the final invoice/contract signed by the client and the moving company;
- If you or the moving company cancels or re-schedules the move you (or your case manager) are responsible for notifying HCS of the cancellation and/or new moving date;
- You are responsible for the scheduling and coordination of your move with the moving company you have selected;
- It is important that you provide the moving company with an accurate and complete inventory of all items to be moved along with details about the locations you are moving from and to. The moving company that you selected has provided you with an estimate of the cost for performing your move based upon these details. Be aware that the payment made by HCS will be based only upon this estimate and that the cost for the actual move may be higher in cases where additional time is spent beyond the estimate. For example, adding items to move that were not included in the original inventory provided to the moving company or having the moving company pack your belongings can cause the cost of your move to increase significantly.
- Prior to your moving day you must have your belongings packed and prepared for the moving company. You should discuss with your mover acceptable packing standards that will minimize the time necessary to perform your move. Failure to have your belongings properly packed and prepared for the move may result in increased moving costs;
- You must be present for the entire moving process, including providing the moving company access to the location you are moving items from and the location you are moving items to

I have read, understood, and accept the terms and expectations of the EFA Moving Assistance Program detailed above.

Applicant Signature: _____ **Date** _____

I have read, reviewed, and discussed the terms and expectations of the EFA Moving Assistance Program detailed above with my client.

Case Manager Signature: _____ **Date** _____

Request for Taxpayer Identification Number and Certification

**Give form to the
 requester. Do not
 send to the IRS.**

Print or type
 See Specific Instructions on page 2.

Name		
Business name, if different from above		
Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶
Address (number, street, and apt. or suite no.)		<input type="checkbox"/> Exempt from backup withholding
City, state, and ZIP code		Requester's name and address (optional)
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Social security number								
or								
Employer identification number								

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here

Signature of
 U.S. person ▶

Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515**, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9**.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);
2. The United States or any of its agencies or instrumentalities;
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or
5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;
7. A foreign central bank of issue;
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;
10. A real estate investment trust;
11. An entity registered at all times during the tax year under the Investment Company Act of 1940;
12. A common trust fund operated by a bank under section 584(a);
13. A financial institution;
14. A middleman known in the investment community as a nominee or custodian; or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15**.

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13 . Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt recipients 1 through 7 ²

¹ See **Form 1099-MISC**, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office or get this form on-line at www.ssa.gov/online/ss5.html. You may also get this form by calling 1-800-772-1213. Use **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at www.irs.gov.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Writing "Applied For" means that you have already applied for a TIN **or** that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or single-owner LLC	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ **You must show your individual name**, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.





What We Offer

Employment Program

Application for Milestone

Milestone Requirements

Re-entry Flyer

Mentee Flyer

Drop-In Flyer

HIV Flyer

Free HIV Testing



Our mission is to serve the needs of women returning into the community and provide clients with the tools they need to move themselves beyond poverty and homelessness into permanent self-sufficiency.

What We Do

Provide stable housing – We provide housing to single adults with a safe, secure, and supportive place to live while they work or receive the training and services needed to rebuild and maintain successful lives. Milestone Place is an SRO for single adults located in the Fort Totten area of Washington DC. Milestone Place applications can be obtained from our Main Office. For more information, contact Shena McFadden: smcfadden@cflsdc.org

Women's Domestic Violence Housing Program- We offer transitional housing to women who are reuniting with their children upon returning to the community after incarceration. Housing is available for women who is victim of domestic violence and is in of stable/safe housing. For more information, please contact Michelle Holmes: mholmes@cflsdc.org or April Shepherd ashepherd@cflsdc.org.

Women's Reentry Housing Program- We provide release planning and intensive case management to women in the community as well as while they are housed in the Correctional Treatment Facility, Fairview Halfway House and Bureau of Prison so they can be stable and safe when they return to the DC community. For more information, please contact April Shepherd: ashepherd@cflsdc.org or Michelle Holmes: mholmes@cflsdc.org

Women's Wellness and Care for People with HIV/AIDS - We provide specific programming for women to maintain their physical and mental wellbeing. We also provide medical case management, free on-site HIV testing, prevention 101, and supportive services to help people with HIV/AIDS manage their wellness and overall health. For more information, contact Shelby Wallington: swallington@cflsdc.org or Diane Carter-Bryant: dcarter-bryant@cflsdc.org or Whitney Arkin: warkin@cflsdc.org

Mentor Families – We match families with trained mentors to empower and support them by sharing financial, educational, parental, and household management ideas and tips. For more information, contact Katherine Sponaule: ksponaule@cflsdc.org or Justin Flemmings: jflemmings@cflsdc.org

Parenting Program - We lead groups to educate parents and guardians of children about new concepts and techniques to make the challenges of raising children easier. For more information, contact Bianca Matthews: bmatthews@cflsdc.org or Maeesha Saeed: msaeed@cflsdc.org

Employment Services – We provide individualized assistance with resume writing, interviewing skills and locating job opportunities. For more information, contact Rhonda Deskins: rdeskins@cflsdc.org

Emergency Services - We help address unexpected needs by providing food, clothing, and referrals for financial assistance. We provide food on Tuesdays from 10:00am -4:00pm. We provide clothing for women on Wednesdays and Thursdays from 10:00am – 12:00pm. And, on Fridays from 10:00am – 12:00pm we distribute clothing for men. For more information, please contact Bria Washington: brwashington@cflsdc.org or Mahendra Supeno: msupeno@cflsdc.org or Justin Flemmings: jflemmings@cflsdc.org

Volunteering- We offer a variety of volunteer opportunities, from one day projects for individuals or groups to long-term mentoring relationships. If you want to volunteer, reach out and we will identify the best way for you to share your energy, compassion, time and talents. For more information, please contact Bria Washington: brwashington@cflsdc.org

If you are a woman who is returning to the community following a period of incarceration, come see us. We offer access to computers, employment services and other services as needed. TO LEARN MORE OR TO SCHEDULE AN APPOINTMENT CALL US: 202-347-0511 OR VISIT US at 305 E. Street, NW Washington DC, 20001 HOURS: Monday – Friday, 10am-4pm. Walk-ins welcome.



CFLS EMPLOYMENT PROGRAM

What We Offer

Community Family Life Services is a nonprofit working with low-income families and women returning home after incarceration to move them toward higher self-efficacy and permanent self-sufficiency. The Employment Program offers one-on-one, individually tailored plans to move clients toward their career or employment goals. We partner with local businesses and nonprofits to expand employment opportunities and streamline our clients' application process. Our services are free. We accept walk-ins from 10am – 4pm, but appointments are preferred.



**Monthly
Employment
Readiness Clinics**

**Weekly Assistance
Clinics for Online
Job Applications**

**GED Software
Program and
Tutoring Hours**

Mentorship

**Assistance Building
& Tailoring your
Résumé**

CFLS EMPLOYMENT PROGRAM

Call Rhonda Deskins at 202-864-6304 or email rdeskins@cflsdc.org, or Katherine Sponaugle at 202-864-6310 or ksponaugle@cflsdc.org.

305 E Street NW
Washington, DC 20001
www.cflsdc.org



Application for Services

Date _____

First Name: _____ Last Name: _____ Middle Initial: _____

Alias: _____

Social Security _____ - _____ - _____

Birthday: _____ Place of Birth: _____

Sex: _____ Ethnicity: _____

Marital Status (please circle): **Single** **Married** **Divorced** **Separated**

US Citizen? _____ Immigration Status: _____

Registered voter? _____

Current Address _____

City: _____ State: _____ Zip Code: _____

County: _____ How long have you lived at current address? _____

Do you anticipate a change in address? ___ Yes ___ No If yes, when? _____

Home Telephone: _____ Work Telephone: _____

If homeless, please complete the following:

Primary reason: _____

Secondary reason: _____

First time homeless? _____

Date became homeless: _____



Reason for leaving prior housing: _____

Name of shelter/institution where you are presently staying: _____

If in housing program, list case manager's name and number.

Name: _____ Phone #: _____

Have you ever been evicted? _____

If yes, date of eviction? _____

Are you the head of household? _____

Information on Children:

Do you have children? _____

Are they living with you ?

Is there Contact with both children's parents? _____

Please Complete Information below on all of your children:

Childs Name	Date of Birth	School attending	Disability



Do you have children that are not living with you? Yes ___ No ___

If yes, Why? _____

Do you have an open child abuse or neglect cases? Yes ___ No ___

If yes, why? _____

How long has your case been open? _____

Social Worker Name: _____ Telephone#: _____

Address: _____

City: _____ State: _____ Zip code: _____

Do you give Community Family Life Services permission to contact him or her?

Yes ___

No ___

Lawyer Name: _____ Telephone#: _____

Address: _____

State: _____ City: _____ Zip Code: _____

Medical

Current Health Provider **example** (Medicare, Medicaid, Charter Health Care, Blue Cross/Blue Shield)

Organization _____

Is the insurance in your name? ___ If no, please provide name of Primary Insurer:

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

If disabled, please list you and your family member's disabilities:

Primary Disability _____

Disability _____

Disability _____

Disability _____



Presently:

Are you or any members of your family experiencing Health Problems? Yes ___ No ___

Describe _____

Are you or any members of your family taking Medications? Yes ___ No ___

If yes, please list the medications: _____

Allergies? _____

Pregnant? Yes ___ No ___ If yes, receiving prenatal care? _____

Date of last medical exam _____

Are your children's immunizations up to date? _____

Hospitalized in the last 12 months? _____ If yes, explain: _____

History of head trauma? _____ If yes, explain: _____

Other medical notes: _____

Emotional /Mental Health

Have you been hospitalized for emotional or mental condition? _____

If yes, explain _____

Received treatment and/or medication for emotional/mental condition? _____

If yes, explain _____

Taking medication now for mental condition? _____

Self-reported mental illness _____

Documented mental illness _____

Substance /Gambling Use

Ever used drugs or alcohol? _____

If yes:



Type 1 _____ How often? _____
 Type 2 _____ How often? _____
 Type 3 _____ How often? _____
 Type 4 _____ How often? _____

Ever treated for any addiction? _____

If yes, explain _____

AA/NA/GA attendance? Yes _____ No _____ Where? _____

Do you have a sponsor? Yes _____ No _____

Estimated last date of alcohol/drug use? _____

Do you have a problem with Gambling? _____

If yes, how often do you gamble? _____

Employment History

Are you currently working? _____

Present or last employer's name: _____

From _____ to _____

Position/Job Duties _____

Supervisor _____

City _____ State _____ Zip Code _____

Telephone _____ Hours per week _____

Transportation Means: **Car** **Bus** **Rail** **Bike** **Other** (please specify): _____

Health Insurance benefits received? _____

Hourly Wage _____

Reason for leaving _____

Income sources (Enter monthly amount)

Source 1 _____ Total monthly income \$ _____



Source 2 _____

Military Service

Are you in the Active military? _____

Date of entrance and exit for military service? _____

Branch of military _____

Prisoner of War? _____

Service related disability? _____

Veteran? _____

Date of Discharge and location: _____

Legal

Have you been arrested before? _____

Is there currently a warrant out for your arrest? _____

Have you ever been convicted of a crime?

Served jail/prison time? _____

Previous arrest record (please list): _____

Are you on probation or parole? _____

If so give Probation or Parole Officer's Name _____

Phone # _____

Date probation/parole ends? _____

Are you a Domestic Violence offender? _____ Sex offender? _____

Are you a Victim of domestic violence? Yes ___ No ___



If yes, do you have a restraining order? Yes ____ No ____

Have you runaway or been asked to leave by parents? _____
Institutional living (foster home, group home, or residential treatment) situation prior to 18?: Yes ____ No ____

Case Management

Food stamps? ____ How much? _____ TANF? ____ How long? _____

Name of TANF case worker: _____ Phone #: _____

Welfare to Work participant? ____ If yes, name of vender? _____

Termination of Public Assistance benefits? _____ If yes, Date _____

Current Application for Public Assistance? _____

If yes, status of application? _____

Signature of Client

Date

******Customers applying for housing should complete this section, applicants that are not requesting housing can skip ahead to Education Section on page #8.**

Are you on the waiting list for shelter? Yes ____ No ____ If yes, when was the last time you registered or updated your request?: _____

Does the Head of household owe an outstanding balance to the Department of Public and Assisted Housing? Yes ____ No ____ If yes, how much: \$ _____

Have you ever been evicted? Yes ____ No ____ If yes, please complete the following information:

When were you evicted? _____

Why? _____

Have you ever lived in transitional housing? Yes ____ No ____

If yes, please give the name of the organization and the dates that you resided there:

Organization: _____ Date: _____

Have you applied for housing at the Department of Public and Assisted Housing?
Yes ____ No ____



Please list the dates and address of your past residence:

Date: _____ Address: _____

Date: _____ Address: _____

Date: _____ Address: _____

Date: _____ Address: _____

Please list the other occupants that will share housing if you are accepted for a Housing Program:

Name _____ Age _____ Female ___ Male ___ Relationship _____

Name _____ Age _____ Female ___ Male ___ Relationship _____

Name _____ Age _____ Female ___ Male ___ Relationship _____

Name _____ Age _____ Female ___ Male ___ Relationship _____

Name _____ Age _____ Female ___ Male ___ Relationship _____

*******Customers requesting SRO housing only should complete this section.**

Have you ever lived in a community environment? Yes ___ No ___

What did you like about group living?

What did you dislike about community living? _____

Why do you want to commit to basic house rules of a drug and alcohol free building? _____

How do you feel about attending monthly meetings? _____

Education

Highest level of school completed: Elementary ___ Junior High School ___

High School ___ GED ___ College ___ Years completed? _____

Associates Degree ___ Bachelors degree ___ Masters degree ___

Where did you attend High School and /or College?

Goals

What are your educational goals: _____

What are your employment goals: _____



What are your parenting goals: _____

What is your future housing goal: _____

Who should we contact in case of an emergency?

Name: _____ **Telephone:** _____

Address: _____ **Relationship:** _____

References (please include 3):

Name: _____ **Telephone#:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Relationship: _____

Name: _____ **Telephone#:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Relationship: _____

Name: _____ **Telephone#:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Relationship: _____

Signature of head of Household

Date

Completion of this application does not guarantee housing or supportive services.



305 E Street NW
Washington, DC 20001

phone 202.347.0511
fax 202.347.0520
web www.cflsdc.org

Milestone Place, SRO- Eligibility Requirements and Process

1. Applicant must submit completed application at CFLS Main office.
2. Applicant must be considered homeless and able to provide appropriate documentation verifying homelessness.
3. If Applicable, the Applicant must have documented six-months of sobriety from illegal drugs and alcohol.
4. If Applicable, Applicants must pay 30% of their income in rent.
5. Income is not required to enter program. However, if Applicants has income, the following forms of verifiable income are: employment, unemployment, SSI, SSDI, or other support.
6. Applicant will need to demonstrate the ability to participate in a positive manner in activities outside the home such as employment, training/schooling, volunteer services, NA/AA in order to move towards self-sufficiency, which is the Agency's Mission.
7. Applicants must be able to provide the following documentation: State Picture ID, Proof of Income/support, employment, Copy of Birth Certificate, Social Security Card, Medical information, Psycho-social if applicable and a Police Clearance.
8. Current PPD Test results dated within the last 90 days.
9. All clients must be at least 18 years of age.
10. Applicants must be able to successfully complete the DCHA application process and be accepted to the Housing Choice Voucher Program.
11. Milestone does not accept Class-A Sex offenders.

****Milestone maintains a Clean and Sober environment**



Community Family Life Services

WOMEN'S REENTRY

**305 E ST NW
WASHINGTON DC 20001**

For More Info Contact the Case Managers:

April Shepherd

ashepherd@cflsdc.org

(202) 864-6307

Jazzmin Darby

jdarby@cflsdc.org

(202) 851-4084

RELEASE PLANNING

Weekly visits to CTF, providing release planning support, and programming. Quarterly visits to FBOP, such as Hazelton and Philadelphia prisons, including Fairview Halfway House,

CASE MANAGEMENT

Intensive case management, designed to identify, and address barriers of female returning citizens. available on site

HOUSING

Assistance locating Transitional Housing for women and children

IDENTIFICATION ASSISTANCE

Identification Card Voucher
Birth Certificates Voucher



Why have a *Mentor?*

If you are looking for someone who:

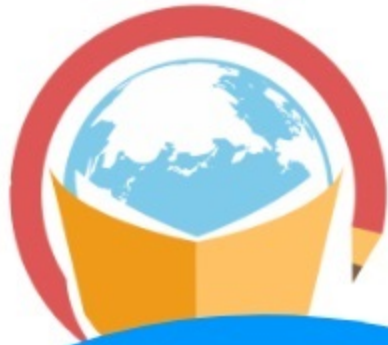
- Encourages you to reach your goals;
- Listens when you need support;
- Broadens your connections in the community; and
- Offers up their knowledge and a different perspective when needed,

WE WILL FIND A MENTOR FOR YOU.

The Family2Family Mentoring Program connects women with mentors and offers support groups, family events, and more to foster your personal growth, hone your communication skills, and move you toward achieving your goals.

Learn more! Contact Katherine (Family2Family Coordinator) at ksponaugle@cflsdc.org or **202-864-6310**





CFLS DROP - IN CENTER

- TUESDAYS: Food bags (10am-12pm)
- WEDNESDAYS: basic computer skills clinics (2-4pm)
- THURSDAYS: Women's Clothing (10am-12pm)
- FRIDAYS: Women and men's clothing (10am-12pm)
- EVERY DAY:
 - ID & Birth Cert. vouchers
 - Diaper distribution
 - Computer lab access
 - Confidential HIV TESTING

CONTACT US

305 E Street NW
Washington, DC 20001



202-347-0511



brwashington@cflsdc.org

DROP IN CENTER HOURS:

10AM - 4PM

(CLOSED FOR LUNCH

1PM-2PM)

REENTRY WOMEN
WELCOME ANY
TIME FOR CARE
PACKAGES,
CLOTHING, AND
FOOD!



VISIT OUR WEBSITE:

www.cflsdc.org



COMMUNITY FAMILY LIFE SERVICES HIV/AIDS PROGRAM

305 E. ST. NW WASHINGTON, DC 20001. FOR MORE INFORMATION, PLEASE CONTACT SHENA MCFADDEN, DIRECTOR OF HOUSING & HIV SERVICES AT 202.635.1744

Services provided: Medical Case Management, Housing Case Management and Non-Medical Case Management

- Medical Case Management services is a strength based approach to service that includes treatment adherence counseling, coordination and follow-up of medical treatments, client advocacy, and assistance in obtaining housing, financial support, legal services, social support and any other needed service. The goal of Medical Case Management is to insure that clients with HIV/AIDS have timely access to comprehensive medical care and social services; prevent disease transmission and delay of HIV progression and to promote and support client independence and self-sufficiency.
- The goal of Housing and Non-Medical Case Management is to assist people living with HIV attain stable housing that supports consistent treatment adherence and retention in medical care and to increase access to support services in order to promote and support self-reliance and improve individual navigation of health and human service systems.
- 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.
- Non-Medical Case Management Services provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services.

Eligibility Requirements

1. Proof of HIV diagnosis- Viral load within 6 months, and/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.
6. For under-insured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare.



30-minute results

**GET
YOURSELF
TESTED.**

free HIV testing



**EVERY TUESDAY AND
THURSDAY VISIT 305 E
STREET NW, WASHINGTON
DC, 20001**

**GET YOUR HIV TEST AND
A 15 MINUTE**

INFORMATION SESSION

- GAIN ACCESS TO VARIOUS CFLS SERVICES:**
- COMPUTERS, PHONES, TOKENS, PRINTING**
- FOOD DISTRIBUTION ON TUESDAYS 10:00-12:00**
- CLOTHING DISTRIBUTION: WED, THURS FOR
WOMEN & FRI FOR MEN**
- EMPLOYMENT SERVICES BY APPOINTMENT**
- MILESTONE SRO HOUSING PROGRAM**
- FEMALE REENTRY CASEMANAGEMENT**
- MEDICAL CASE MANAGEMENT**
- DIAPER PROGRAM**
- VARIOUS MONTHLY WORKSHOPS**



Community Family Life Services (CFLS) has been working tirelessly to serve the needs of Washington, D.C.'s most vulnerable citizens for nearly half a century. We provide holistic community reentry services for women returning home from periods of incarceration. We support women seeking healing, redemption and a second chance at life



HIV/AIDS, HEPATITIS, STD AND TB ADMINISTRATION

**COMPREHENSIVE CASE MANAGEMENT QUARTERLY TRAINING:
“HOUSING OPPORTUNITIES & CHALLENGES FOR PERSONS LIVING WITH HIV”**

Kellogg Center at Gallaudet University, Washington, DC

April 18, 2019

Housing Resource Tables:

1. Casa Ruby
2. Community Family Life Services
3. Cornerstone Community
4. Homes for Hope
5. Housing Counseling Services
6. Housing Up
7. N Street Village
8. SOME - So Others Might Eat

THE EFFI BARRY TRAINING INSTITUTE

ADVANCING INNOVATIVE, COLLABORATIVE, INTEGRATED HIV SERVICES

The Effi Barry Training Institute provides training and capacity building assistance to support current and prospective HAHSTA grantees and community-based organizations. The Institute is designed to **strengthen the capacity** of the HIV prevention and care workforce to optimally **plan, implement, and sustain** HIV high-impact prevention and care interventions and strategies.

Training and capacity building assistance
is provided in the following formats:



In-Person

- Group-Level Trainings
- Boot Camps
- Community Forums
- Individual Consultations



Online

- Modules
- Webinars
- Training Guides
- Resource Library

Request training and capacity building assistance
by visiting EffiBarryInstitute.org

THE EFFI BARRY TRAINING INSTITUTE

ADVANCING INNOVATIVE, COLLABORATIVE, INTEGRATED HIV SERVICES

Rooted in the idea of holistic, integrated, patient-centered care, the Institute's capacity building efforts help develop organizations' abilities to improve patient outcomes and increase efficiencies, while remaining sustainable.

Capacity building assistance is provided in the following content areas:

- 340B Program Compliance and Management
- Budgeting & Projection Skills
- Data Sharing
- Faith Communities
- Fee-for-Service Reimbursement
- Health Literacy
- HIV Basics
- HIV Care & Treatment
- HIV Epidemiology
- HIV Prevention & Biomedical Interventions
- Housing & HIV Prevention
- Mental Health
- Navigating Health Insurance
- Nonprofit Financial Basics
- Social Determinants of Health
- Stigma & Cultural Competency
- Substance Use & HIV
- Trans Cultural Competency
- Unit Cost Development

To request free capacity building assistance, email EffiBarry@HealthHIV.org or call (202) 232-6749.