NEW YORK STATE | Office of Addiction Services and Supports

Permanent Supportive Housing Program Guidelines

2020

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Permanent Supportive Housing
Program Guidelines

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MISSION STATEMENT

The Office of Addiction Services and Supports (OASAS) believes that safe and affordable permanent supportive housing, along with stable living wages and individualized person-centered Service Plans are essential components for successful long-term stable housing, which in addition, can promote and support the attainment of self-sufficiency. The funding and provision of Permanent Supportive Housing (PSH) is a means by which OASAS supports homeless families and individuals with histories of substance use disorders in achieving these goals.

INTRODUCTION

OASAS requires that every Permanent Supportive Housing program (PSH) have documented Policies and Procedures that are clearly written and understood by all program staff. Having clear policies and procedures in place provides support and resources to staff and enables supportive housing projects to operate and run smoothly. Moreover, clear and efficacious policies and procedures ensures there is consistent and predictable problem solving, as well as, appropriate responses to important events.

These Permanent Supportive Housing Program Guidelines represent the OASAS Housing Bureau's expectations for our funded and contracted housing Providers and is an important guide as to who does what, when, and how often. This would include the expected frequency of processes and encounters with tenant participants, what forms and documentation to use, and what resources are available to assist in the permanent supportive housing of families and individuals with substance use disorders (SUD). At a minimum, the Providers' housing manual should outline the expectation/performance of critical functions such as 24 hour/seven (7) day emergency on-call systems, fire safety procedures, and responses to tenant(s') crises. Policies and procedures should also be periodically reviewed with all staff involved in the housing program and revised throughout the operation and delivery of the housing services.

These OASAS Guidelines serve as a resource for our funded PSH Provider agencies, as well as those agencies that have a partnership with those Providers in the delivery and provision of permanent supportive housing. This document contains information regarding program implementation, and outlines OASAS' expectations for program operation. These guidelines also provide agencies with an understanding of the programmatic elements OASAS will review during Site Visits.

The OASAS Permanent Supportive Housing Model (PSH)

Every OASAS PSH program offers rental subsidies, as well as on-site Case Management with housing counselor services, instruction in "daily living" skills enhancement, linkages to appropriate and targeted referral services, and when indicated, referrals to Health Homes for primary care and behavioral health services.

Expectations of All OASAS PSH Programs:

- Compliance with Home and Community Based Services (HCBS) settings;

- Rental subsidies at the full Fair Market Rent (FMR) set by the United States Department of Housing and Urban Development (HUD) for each community. This includes the expectation that individuals and families participating in the housing program will contribute financially to the actual rent due to landlords;

- Leases that are held by either the program participant or the provider agency;

- Occupancy Agreements, which specify program expectations regarding continued occupancy. Occupancy Agreements must be signed by program participants and agency staff;

- Apartment leases that can be "turn-keyed" where the individual's or family's income is sufficient to assume full rental responsibility (moving from subsidized to unsubsidized housing) without needing to move;

- On-site Case Management services during daytime hours, as well as evenings and weekends; and

- Vocational/Educational Counseling services that include job development, post-employment support groups, and access to skills training to aid career growth.

Overall Goals of PSH Programs

It is expected that Providers of OASAS PSH programs will work with and engage program participants in, sustaining stable housing; establishing linkages to supportive services and mainstream benefits; increasing participants' employability skills; meeting any legal obligations; encouraging integration into the community; and when indicated, assistance in the development and implementation of academic/educational goals and requirements of families with children. ***It is OASAS' expectation that agencies will incorporate such goals in participants' Service Plans, document their progress in case notes and service plan updates, and when indicated, family member's progress.***

- ***Maintain stable housing*:** Having a stable and sustained living arrangement is an important part of transitioning to independence and achieving self-sufficiency.

- ***Linkage to community resources and support services:*** Services for Substance Use Disorders, mental health, physical health, and other community-based supports and resources are very important for individuals and families when beginning and sustaining the process of community re-integration.

- ***Linkage to mainstream benefits***: It is important to link participants to mainstream benefits. Those entitlement programs can provide Medicaid, as well as, access to the Women, Infants and Children (WIC) program, food stamps [Supplemental Nutrition Assistance Program (SNAP)], and in some instances, cash assistance until the individual can secure stable employment. Teaching participants in how to take an active part in securing and advocating for these entitlement programs and social-supports are important in building independence, as well as, supporting the goals of self-reliance/self-efficacy.

- ***Increased Vocational and Employability Skills:*** As a result of homelessness, many individuals can have difficulty finding permanent, well-paid employment because they lack viable work histories, job-seeking skills and/or occupational experiences. Providing or linking program participants with opportunities to build skills that focus on obtaining vocational, educational, and employment opportunities will increase their chances for a successful re-integration into society and the community. In addition, increasing vocational and educational skills that will assist families and individuals in securing and maintaining unsubsidized stable housing**.**

Getting Your Project off the Ground/Start-Up

Once a contract has been awarded and executed with OASAS, launching the project requires careful coordination of supportive services and housing. Factors to consider when starting a PSH program include:

- Housing First
- Site Selection
- Staffing

Housing First

Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent supportive housing without preconditions and barriers to their entry. Typical barriers can include being in recovery, being in treatment/or having completed treatment for a substance use disorder or requiring any other service participation requirements. All permanent supportive housing Providers are expected to utilize the Housing First approach, which is premised on the following principles:

- Homelessness is first and foremost a housing crisis and can be addressed through the provision of safe and affordable housing.

- All people experiencing homelessness, regardless of their housing history and duration of homelessness, can achieve housing stability and permanent housing. Some families and individuals may need minimal supports for a brief period, while others may need more intensive and long-term support services.

- Everyone is "housing ready." Being in recovery, compliance in treatment, and/or criminal and incarceration histories are not deterrents to housing, or individuals' ability to succeed in maintaining housing. It is expected that homelessness programs and housing Providers be "consumer ready."

- As a result of sustained safe, and affordable housing, many people experience improvements in the quality of their lives, especially in the areas of physical health, mental health and addressing substance use disorders, as well as the achievement of stable employment.

- People experiencing homelessness have the right to self-determination and should be treated with dignity and respect.

- The exact configuration of housing and services depends upon the needs and preferences of the individual(s) and populations being housed.

Site Selection

Home and Community Based Services Setting Compliance

In 2016, OASAS determined that all Permanent Supportive Housing settings shall be compliant with the Center for Medicaid and Medicare Services (CMS) Home and Community Based Services (HCBS) Federal Settings Rule (42 CFR 441.301, *et.seq.*). These rules clarified the settings in which Medicaid recipients may reside and access HCBS services, either onsite or in the community. The rule outlines specific characteristics and requirements for settings to be considered "home and community based", such as:

- The setting is integrated in and supports full access to the greater community;
- The setting is selected by the individual from among setting options, including non-disability specific settings;
- The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- The setting optimizes autonomy and independence in making life choices, including the option for a private unit in a residential setting;
- Facilitates choice regarding services and who provides them; and
- The options are based on the individual's needs, preferences, and for residential settings, resources available for room and board.

In addition to the settings standards otherwise identified, the federal HCBS rule also requires a person-centered planning process. This process must:

- provide necessary information and support to the individual to ensure that they can direct their planning process as much as possible;
- include people chosen by the individual;
- be timely and occur at least annually at times and locations of the individual's convenience;
- assist the person in achieving outcomes they define for themselves, and in the most integrated community setting(s) they desire;
- ensure delivery of services in a manner that reflects personal preferences and choices;
- help promote the health and welfare of those receiving services;
- take into consideration the culture of the person served;

- use plain language;
- include strategies for solving disagreement(s);
- offer choices regarding the services and supports the person receives, and from whom;
- provide a method for the individual to request updates to their plan;
- indicate what entity or person will monitor the primary or main person-centered plan;
- identify individual's strengths, preferences, needs (both clinical and support), and desired outcomes.

Under this rule, non-compliant settings are also defined. *Individuals residing in non-compliant settings are unable to receive federally funded Medicaid HCBS, even if they are receiving other Medicaid funded services.* The following settings are deemed non-compliant and are NOT considered a home and community-based setting:

- Settings that provide inpatient institutional services;
- OASAS certified residential programs;
- Settings in facilities on the grounds of, or immediately adjacent to, a public institution;
- Any settings that serve to isolate individuals from the broader community.

OASAS' Permanent Supportive Housing units must be compliant with the HCBS rules. Any existing housing units that are isolated from the community, in a facility that provides inpatient institutional services, or sited on the grounds of facilities providing inpatient institutional services must undergo a heightened and targeted scrutiny test. **Any new permanent supportive housing units developed or created must be in compliance with these rules, and no exceptions will be made.**

Providers should use the following criteria as a guide when identifying housing units:

<u>Housing Units:</u>

- Housing Units should be integrated into the broader community.
    - Residents should be able to seek and access employment, engage in community life, and easily access services within the community.
    - Housing Units should be selected by the individual from among a choice of options.
    - Options should be based on the needs of the individual and family, including access to disability-enabled specific settings.

- Options and selections should be identified in the resident's person-centered individualized Service Plan.
- Options should ensure the resident's rights of privacy, including their right to dignity, respect, freedom from coercion, or fear of any retaliation.

Participant Autonomy:

- The resident's person-centered individualized Service Plan should facilitate choice regarding services and supports, and the Provider delivering the services.
- The person-centered individualized Service Plan should ensure and reflect that participants are making independent decisions regarding their life choices including but not limited to, daily activities, physical environment, access to food at any time, and with whom they wish to interact.
- Each resident should have privacy in their housing unit with the possession of keys and ability to lock their doors, as well as the freedom to furnish or decorate their apartment unit, and all in accordance with any lease agreement.
- Only appropriate housing program staff should have keys to the unit. Such staff should be identified to the resident and should make notification of an intention to enter the apartment unit.
- Residents should have a choice in roommates, when required to share an apartment unit with an un-related program participant.
- Residents shall have the ability to control their own schedule and activities.
- Residents shall have the ability to control their personal resources and finances.
- Residents shall have the ability to have visitors at any time.

Legal Rights:

- The unit should be owned, rented, or occupied under a legally enforceable agreement by the resident.
- The resident should have, at a minimum, the same responsibilities and protections from eviction that tenants have under the local or state's jurisdiction's landlord/tenant law or equivalent.
- Providers may not restrict resident activities that are otherwise legal.

Housing Units

The PSH Provider agency is expected to identify and furnish "appropriately-sized" apartment units for eligible program participants. When working with landlords/building owners, realtors, and/or brokers it is important to factor in program participants being able to access community support services such as medical services, laundry facilities, grocery stores, and when indicated,apartment units/buildings that are accessible to participants with handicaps and/or physical limitations. Realty agencies and property management companies can be an asset to not-for-profit Providers when locating and leasing apartment units for residents, especially in New York City. When developing start-up budgets, in some cities and suburbs, broker fees are often a necessary component in locating affordable apartment units.

It is important for Providers to locate, rent, and furnish the apartment units during the "start-up period" of the contract so the agency does not have to utilize money in their annual budgets for these additional costs. In addition, the Provider agency is obligated and expected to obtain and maintain the specific number of apartment units it has been funded for under their contract with OASAS.

Different Models for apartment unit configurations may include:

- **Scatter-Site Model** -- Program participants are placed in apartment units scattered throughout a community, or 'scattered' within a large apartment building.
- **Clustered-Scattered Site Model** -- The project operates two or more smaller apartment buildings of no more than eight units, sometimes with as few as two units.
- **Single-Site Mixed-Use Building** – These models provide units in one building. These housing constructs enable program participants in occupying a portion of the building's apartment units within a mix of affordable, generally non-subsidized housing units. Providers can develop these models through, but not limited to a set-aside with building owners/landlords, the obtaining of 'Master-Leases,' or making other documented arrangements with a housing developer. These are the preferred models for developing an affordable, special needs housing site.

Fair Market Rent (FMR)

Unless the housing Provider already owns the building, agencies will need to locate property owners and/or landlords willing to lease individual apartments or a cluster of apartment units preferably at the 'fair market rate' established for the region in which the apartments will be sited. The fair market rates published by U.S. HUD and stratified by apartment unit size, i.e., number of bedrooms, can be found at http://www.huduser.org/DATASETS/fmr.html. Providers should ensure that rents being paid are reasonably established as they relate to the average rental amounts being charged for comparable unassisted apartment units, in the same market. It is important to note that program budgets are based on the FMR established during the year housing projects and initiatives were awarded and funded. Providers should remember that when renting apartment units, New York State contracts generally cover multiple years and are often funded without any annual rental escalators. ***Additional funding will NOT be made available to accommodate increases in the cost of leasing and renting apartment units; or to reflect annual rate changes in the FMR established by U.S. HUD.***

Housing Quality Standards

The building and the apartment units selected for participants must be clean, in good repair, and free from any conditions that could be a safety hazard, dangerous, or unhealthy for the individual and family. There may be occasions when buildings and/or apartment units require repairs, which when indicated, must be completed prior to the occupancy of participants.

Housing units must meet the Housing Quality Standards set forth by U.S. HUD in federal guidelines 24 CFR Section 982.401. The housing Provider must initially inspect the building and apartment(s) using HUD's Housing Quality Inspection Checklist (see Appendix B). **(Note**: ***If the agency owns the property, the inspection must be completed by an outside independent entity.*)** The Housing Provider should reserve the right to require further repairs, updates, or to reject the housing if it does not meet the standards and/or has major deficiencies that the landlord does not plan to correct.

Going forward the Provider agency must also ensure that each housing unit be re-inspected annually (by the Provider agency or outside independent entity) and all needed repairs must be made within 30 days of the inspection. For annual re-inspections, the program participant and the Case Manager/Housing Counselor should be present to answer questions about the apartment unit(s).

Apartment Set-Up

OASAS PSH programs can request program 'start-up' funds that are an advance of their first quarter's funding, to obtain furniture and necessities for the apartment units. Furniture should be purchased during the start-up period of the contract, to include the providing of bed(s)/bedding, dresser(s), a suitably sized table and chairs, couch, coffee table, lamps (if needed), blinds/curtains, and basic cookware.

A welcome package consisting of items such as sheets, pillow, comforter, shower curtains and towels is recommended. ***The money advanced that is used for 'start-up' comes from, and is limited to, the first quarter of the Providers' contract funding. Therefore, it is important that housing agencies secure all the above items and furnishings during that 'start-up' period.***

It is recommended that Providers have participants sign an acknowledgement that the furniture in their apartment unit is the property of the Provider agency and cannot be sold or taken with them when they move out of the apartment. Some local Department of Social Services (DSS) and the NYC Human Resources Administration (HRA) allow for an additional furniture allowance, which should be used to meet personal needs of residents and acquire items such as plates, sheets, towels, cleaning supplies, etc. ***Any purchases made with DSS/HRA funding is the property of the program participant and does not need to be accounted for by the Provider agency.***

An agreement should be made between the Provider agency and the participant about the furniture, to include stipulations such as:

- participants cannot dispose of or sell any agency furniture;
- participants may request that furniture be removed from the unit by the Provider agency if the individual wants to purchase their own;
- participants will be liable for any damages they make to the agency furniture.

The Provider must keep an inventory of all furniture provided for program participants. All furniture should be tagged and verified during apartment inspections. ***The furniture inventory must be made available for OASAS' review during an on-site visit.*** (See Appendix B for a model Inventory Form.)

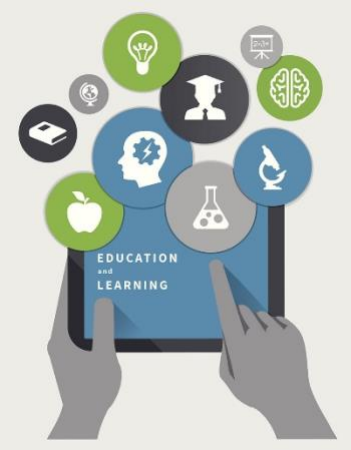
Staffing

Upon execution of the New York State housing contract with OASAS, Providers can begin to interview and hire staff for the program. Providers must conduct criminal background checks in compliance with the Justice Center for the Protection of People with Special Needs. The Provider shall ensure that the program has an appropriate staffing plan with sufficient numbers of employees, with the appropriate qualifications and training, for the target population. Salaries and benefits should be commensurate with those qualifications. Evening and weekend coverage (e.g., seven (7) day/24-hour on-call) is expected. Staff configurations must include a program employee designated as a mandated reporter of child abuse/maltreatment. Program Directors overseeing Case Managers/Housing Counselors shall be required to have a Bachelor's degree with supervisory experience, and experience serving the target population.

Case Managers/Housing Counselors

The Case Manager/Housing Counselor is expected to be available for day-to-day contact with the program participants. The role of the Case Manager/Housing Counselor is to provide support and guidance as it relates to housing assistance, service collaborations, counseling, coaching, and mentoring.

Case Managers/Housing Counselors work with participants to help them learn how to maintain stable housing and advocate in their best interests. Case Managers/Housing Counselors also assist program participants by continually assessing strengths and needs, linking participants to natural support systems, identifying existing community resources, coordinating person-centered individualized Service Plans, and fostering self-sufficiency.



The skill set and activities that makes for an effective Case Manager/Housing Counselor includes but is not limited to; outreach/engagement, screening/assessment, wellness planning, liaisons to linkages, monitoring and advocacy, as well as, knowing the importance of regular documentation of progress, participant interactions, and service plan updates. The Case Manager/Housing Counselor must have expert knowledge of community-based resources, with at least one year's experience in working with people affected by substance use disorders and homelessness. Excellent communication skills, written and oral are also required.

Other responsibilities of the Case Manager/Housing Counselor include:

- Oversight of proper maintenance/cleaning of the apartment unit;
- Assisting the participant with budgeting, menu planning and purchasing nutritious foods, and when indicated developing cooking skills;
- Emphasizing the importance of keeping medical and clinic appointments, taking prescribed medications as indicated by their physician, as well as, encouraging exercise, self-care, and positive use of free time;
- Conducting pre-screenings;
- Conducting intake assessments;
- Knowledge of entitlement programs;
- Developing Service Plans with updates on a quarterly basis;
- Maintaining resident charts/records, and documentation as required;
- Conducting monthly home visits as indicated;
- Offering presentations and outreach for recruitment;
- When indicated, completing case closing documentation and discharge planning

Subcontracting the Case Management / Housing Counselor Services

The contracted provider agency may choose to subcontract the Case Management/Housing Counselor services. In these cases, it is important for the contracting agency to monitor the subcontractor to ensure that the services are carried out in accord with these Program Guidelines. The contracting agency must develop a tracking system which demonstrates that the subcontractor is being monitored to assure contract deliverables are being met. The tracking system must be made available for OASAS' review during an on-site visit.

Staff Training

Providers shall have the capacity and means to provide training to housing staff that would include, but not be limited to, best practices in health education, addiction treatment and recovery, nutrition, efficacious counseling techniques (e.g., Motivational Interviewing and other evidence-based practices), employment services, harm reduction, Housing First approaches, trauma-informed care, and relapse prevention techniques/approaches. Providers should make available training for all new employees, as well as, provide regulatory mandated trainings, opportunities to discuss Quality Improvement, and conduct training updates as needed. ***Program staff training logs must be maintained and made available for OASAS' review during an on-site visit.***

OASAS Housing Brands

OASAS oversees the following brands of Permanent Supportive Housing:

- Medicaid Re-Design Team Permanent Supportive Housing
- New York/New York III Permanent Supportive Housing -- Single Adults and Families
- Re-Entry Permanent Supportive Housing for Parolees in New York City
- Upstate Permanent Supportive Housing
- Empire State Supportive Housing Initiative
- Continuum of Care Case Management

Outlined below is a description of each housing brand, along with the targeted population(s), admission criteria, eligibility and referral processes, and other elements that are unique or germane to that specific housing initiative.

Medicaid Re-Design Team Permanent Supportive Housing

Background

In 2011 Governor Andrew Cuomo established the Medicaid Re-Design Team (MRT) by Executive Order to find ways to reform and improve the Medicaid healthcare system. The MRT identified increasing the availability of affordable supportive housing for high-need Medicaid beneficiaries as a significant opportunity to reduce Medicaid spending. The Governor invited key Medicaid stakeholders to the table in a spirit of collaboration to see what could be achieved collectively to change service delivery and rein in Medicaid spending, while at the same time sustaining and improving quality of care.

MRT Target Population

The target population for the OASAS MRT permanent supportive housing program are single adults with a substance use disorder/chronic addiction, who are high cost frequent consumers of Medicaid benefits, and are homeless or at risk of returning to homelessness.

OASAS Required Criteria for Admission

Specific admission requirements for the OASAS MRT PSH program are as follows:

- Must be a single adult.
- Must have a primary diagnosis of a substance use disorder.
- Must have history of or be at risk of homelessness.
    - At-risk of homelessness includes persons who are in imminent danger of losing their housing due to a sudden change in the building ownership, or the circumstances/life situation of the individual such as:
        - The household has received an eviction notice;
        - Tenants in a building have been informed that a public safety condemnation is imminent;
        - Foreclosure proceedings are pending on the household's rental housing;
        - The household is in an extreme overcrowded situation (the number of persons exceeds health and/or safety standards for the unit's size);

- The person is living in an environment that may jeopardize their recovery (i.e., active substance use; drug sales) and has no financial means of immediately securing alternative permanent housing;
- Sudden and significant loss of income for the household;
- Sudden loss of existing physical accommodations (i.e., elevator no longer works);
- The building has sustained significant damage such as fire, loss of water, loss of heat;
- The individual is pending a discharge from an inpatient facility (i.e., rehab, residential facility, state hospital) AND has no subsequent residence identified and lacks the resources and support networks needed to obtain access to housing due to their substance use disorder.

- Must have active Medicaid benefits.
- Must have a history of two inpatient hospitalizations; OR, at least five emergency room episodes; OR, a combination of four emergency room episodes and one inpatient hospitalization in a 12-month period to be eligible.
    - The 12-month period is specific to the 12 months prior to the date of referral to the MRT housing program, OR 12 months prior to the date of entry to a community residence program, supportive living program, or other transitional housing programs.

MRT Referral Process

Housing providers are encouraged to identify potential referral sources and establish working agreements. MRT Housing providers are expected to link with a Health Home in their community and should reach out to them as a source of referrals that will meet the above criteria. Behavioral Health Organizations (BHO) may also serve as a referral source, as well as utilizing pre-existing referral networks.

Interviewing and Selecting Eligible Participants

Based on an individual meeting initial eligibility criterion, the agency will screen the applicant to confirm that they meet all required admission criteria, including Medicaid verification. The housing agency should keep any Referral Forms and Intake Forms in the case-record/charts of all accepted program participants. See Appendix B for sample forms.

MRT Housing Consent Form

The MRT program requires the collection of Medicaid data from each program participant admitted to the program. Due to the confidential nature of the information, all MRT program participants are required to complete OASAS form TRS-60 – "Consent to Release of Information Concerning Chemical Dependence Treatment for Permanent Supportive Housing" (see Appendix B). Details regarding the data collection are described later in these guidelines.

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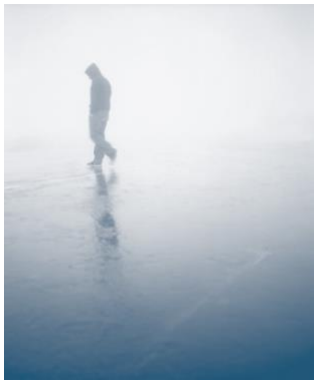
New York/New York III

Background

The New York New York III (NY/NY III) Permanent Supportive Housing initiative resulted from an agreement between New York State and New York City (NYC) to jointly develop supportive housing units to address homelessness in NYC. The agreement provides for the development and funding of both congregate (single-site buildings) and scatter-site supportive housing models, targeting homeless single adults who have completed some level of substance abuse treatment, as well as chronically homeless families and families at serious risk of becoming chronically homeless, in which the head of household suffers from a substance use disorder.

NY/NY III Target Populations

The OASAS NY/NY III program targets two populations:



Population F – Homeless single adults who have completed a course of treatment for a substance use disorder and are at risk of street homelessness, or sheltered homelessness, and who need supportive housing to sustain sobriety and achieve sustained independent living.

Population G – Chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of household suffers from a substance use disorder.

NY/NY III Eligibility and Referral Process

The eligibility of an individual or family seeking PSH housing under the NY/NY III agreement will be determined by the NYC Human Resources Administration (HRA) post submission of the

supportive housing application (HR2010e) by the individual, or anyone acting on their behalf such as but not limited to an outreach worker, case worker/manager, shelter, or drop-in center staff. The NYC Department of Homeless Services (DHS) will be responsible for placing the approved applicants by sending NY/NY III housing Providers a limited but reasonable number of eligible individuals/families from which the housing program will be required to select an applicant(s) for placement in an apartment unit.

Development Strategies for Population G - Chronically Homeless Families

In accord with the NY/NY III Agreement, the units for Population G shall be congregate (single-site) housing, in which a site will be acquired, and a building constructed or renovated for the purpose of providing apartments of a size and character that conform to applicable State and City laws and regulations. The units developed in this fashion may be a part of a larger building. Supportive services will be provided by a qualified Provider.

It is critical to 'quickly' move families from homeless shelters as soon as housing units become available. To accomplish that objective, Providers could use either the Direct Approach or the Two-Phase Approach. Under the Direct Approach, Providers that already own or control a building that is ready for occupancy could place families directly into those apartment units. In cases where the single-site building is not yet ready for occupancy, providers would use the Two-Phase Approach. In using the Two-Phase approach, Provider agencies would lease scatter-site apartments from private landlords ideally in the same neighborhood planned for the siting and construction of the single-site building. Once that single-site building is completed and ready for occupancy, families would relocate from their scatter-site units to the new single-site building. This Two-Phase Approach is acceptable ONLY for NY/NY III Population G, targeting families.

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Re-Entry Permanent Supportive Housing Initiative for Parolees in New York City

Background

In 2009, the Re-Entry Permanent Supportive Housing (PSH) Initiative was designed to address the anticipated demand for housing resulting from the reform of New York's drug laws, with a special focus targeting parolee, with histories of substance use disorders, returning to their communities. It was expected that the sentencing reforms would increase the need for permanent

housing, as OASAS projected that at least twenty percent of those persons released on parole into mandated addiction treatment would be functionally homeless at that point in time.

Re-Entry Target Population

The target population for the Re-Entry PSH Initiative are persons with substance abuse problems who are being released on parole to New York City and would be functionally homeless if not provided an opportunity to be placed in this PSH program. OASAS recommends that participants in the Re-Entry program are provided single-person units. History with this population has shown that "doubling-up" in an apartment with other unrelated adult roommates that may be actively engaged in either drug seeking, or criminal behaviors presents high risks for relapse and/or recidivism. To optimize participants' potential in successfully sustaining their housing and recovery, room-mating is not an acceptable or recommended housing option.

Re-Entry Client Referral and Placement

The NYS Department of Corrections and Community Supervision will refer eligible participants to the Re-Entry PSH housing provider agency. The agency will complete a history and screening which will determine if the prospective participant is appropriate for the Re-Entry housing program.

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Upstate Permanent Supportive Housing Initiative

Background

The Upstate PSH Initiative was developed with the intention of increasing the number and location of permanent supportive housing units outside of New York City and Long Island. In that endeavor, OASAS targeted Upstate counties, rural communities, and smaller suburban regions to enhance permanent supportive housing opportunities and impact homelessness in those upstate communities.

Upstate PSH Program Target Population

The targeted populations are single adults and families in recovery from a substance use disorder, who began a course of treatment and/or their recovery when they were homeless. Program participants can be actively engaged in outpatient treatment when they enter the Upstate PSH program. Program participants could have also completed a formal course of treatment, and in some instances, may have chosen a different recovery pathway to formal counseling services. An individual's recovery pathway could include but may not be limited to Twelve-Step support

group participation, faith-based experiences, natural supports, or any other personal recovery involvement.

Upstate PSH Referral Process

Upstate PSH Providers can accept referrals from various sources within the community. That would include but may not be limited to local Department of Social Service offices, other treatment providers in their region, as well as referrals from within their own agency network. The PSH housing Provider should complete an assessment to determine whether the applicant is appropriate for admission into the housing program. Providers must maintain documentation which demonstrates that the participant has a substance use disorder and is homeless or at risk of becoming homeless.

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Empire State Supportive Housing Initiative

Background

The Empire State Supportive Housing Initiative (ESSHI) provides operational and supportive services funding to Providers for the development of new or rehabbed housing units for persons identified as homeless with special needs, conditions, or other life challenges. The ESSHI program operates under the guidance of the Empire State Supportive Housing Initiative Inter-Agency Workgroup, which is comprised of representatives from several State agencies including:

- Department of Health (DOH) including the AIDS Institute
- New York State Homes and Community Renewal (HCR)
- Office of Addiction Services and Supports (OASAS)
- Office of Children and Family Services (OCFS)
- Office of Mental Health (OMH)
- Office for the Prevention of Domestic Violence (OPDV)
- Office of Temporary and Disability Assistance (OTDA)
- Office for People with Developmental Disabilities (OPWDD).

The ESSHI Program requires Providers to secure capital funding to fully finance their housing project(s) within one year of receiving their Conditional Awards for operational/supportive services funding.

ESSHI Target Population

The eligible target populations to be served under the ESSHI program are families, single adults, and young adults, who are homeless (see below for definition); identified as having an unmet housing need as determined by the regional Continuum of Care (CoC), local planning entity, or through other supplemental local, state and federal data; and having one or more disabling condition or other life challenge(s), including:

- Serious Mental Illness (SMI);
- Substance Use Disorder (SUD);
- Persons living with HIV or AIDS;
- Victims/Survivors of domestic violence;
- Military service with disabilities (including veterans with other than honorable discharge);
- Chronic homelessness as defined by HUD (including families, and individuals experiencing street homelessness or long-term shelter stays);
- Youth / young adults who left foster care within the prior five years and who were in foster care at or over age 16;
- Homeless young adults between 18 and 25 years old;
- Adults, youth or young adults reentering the community from incarceration or juvenile justice placement, particularly those with disabling conditions;
- Frail or disabled seniors;
- Individuals with I/DD; and
- Individuals who are Medicaid Redesign Team (MRT) high cost Medicaid populations (i.e., MRT program eligible)

ESSHI Homeless Definition

The Empire State Supportive Housing Initiative program requires an individual to meet one of the criteria below to be considered homeless and eligible for housing:

(1) be an un-domiciled person (whether alone or as a member of a family) who is unable to secure permanent and stable housing without special assistance. This includes those who are inappropriately housed in an institutional facility and can safely live in the community, and those who are at risk of homelessness;

(2) be a youth or young adult who left foster care within the prior five years and who was in foster care at or over age 16, and who is without permanent and stable housing;

(3) be an adult or young adult reentering the community from incarceration or juvenile justice placement, who was released or discharged, and who is without permanent and stable housing; or

(4) be a young adult between the ages of 18 and 25 years of age without a permanent residence, including those aging out of a residential school for individuals with an intellectual or developmental disability.

ESSHI Referral Process

ESSHI Providers are expected to follow the referral processes outlined in the application they submitted in response to the Request for Proposals. The PSH housing Provider should complete an assessment to determine whether the applicant is appropriate for admission. Providers must maintain documentation which demonstrates that the participant is part of the targeted population(s) that the Provider is contracted to serve.

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Continuum of Care Case Management

Background

The Continuum of Care (CoC) Rental Assistance Program (formerly known as Shelter Plus Care) is funded through U.S. HUD and is designed to link rental assistance with supportive services for homeless and disabled persons and their families. HUD provides funding for rental assistance through a direct contract with housing provider agencies. Housing Providers deliver or arrange supportive services for individuals and families participating in the program. OASAS provides state-aid funding to Providers that is dedicated exclusively for Case Management and delivery of supportive services to the participants in the CoC Rental Assistance Program.

HUD's Continuum of Care Rental Assistance Program is periodically revised. Modifications may be made annually during the Notice of Funding Availability (NOFA), and at other times in the year as determined by HUD and/or the U.S. Congress. **It is important that CoC Rental Assistance Program providers maintain contact with their local Continuum of Care Planning Body and their regional HUD office to ensure continued compliance with HUD requirements.**

Continuum of Care Rental Assistance Program's Target Population

The CoC Rental Assistance Program serves persons who are both homeless and disabled. Specific disabilities targeted by HUD are persons who are; seriously mentally ill, have chronic problems with alcohol and/or drugs, have been diagnosed with acquired immunodeficiency syndrome (AIDS) or HIV-related diseases, or have intellectual developmental disabilities. Providers that receive Case Management funding from OASAS, for the purpose of providing supportive services to participants in the CoC Rental Assistance Program, are required to target for referral to their housing unit's homeless persons with a diagnosable substance use disorder. There may be some referral instances wherein a participant will also have a co-occurring disorder or disability, such as mental illness, HIV, or AIDS.

HUD's Definition and Documentation of Disability

The definition of disabled [24 CFR 583.5] that is used as the basis for determining eligibility in the CoC Rental Assistance Program is as follows:

A household must be composed of one or more persons, at least one of whom is an adult who has a disability. HUD defines "disability" as follows:

(A) A condition that:
- (i) Is expected to be long-continuing or of indefinite duration;
- (ii) Substantially impedes the individual's ability to live independently;
- (iii) Could be improved by the provision of more suitable housing conditions; and
- (iv) Is a physical, mental impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;

(B) A developmental disability; or

(C) The disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).

Key to the definition is determining that the impairment is of long, continued, and indefinite duration; AND **substantially impedes** the person's ability to live independently. Providers must have written documentation in their case records that supports and qualifies each participant as

having met the program definition of "disabled," from an appropriate professional, and/or through the local Continuum of Care Coordinated Entry process. ***Questions regarding the definition or documentation of disability should be addressed to the local Continuum of Care Planning Body or the regional HUD office***.

HUD's Definition and Documentation of Homelessness

There are four possible categories under which individuals and families may qualify as homeless to participate in a HUD housing program:

Category 1 – Literally Homeless

Category 2 – Imminent Risk of Homelessness

Category 3 – Homeless Under Other Federal Statutes

Category 4 – Fleeing/Attempting to Flee Domestic Violence

IMPORTANT - For the CoC Rental Assistance Programs, ONLY Category 1 and Category 4 are eligible for housing services. See Appendix B for more detailed information on the categories that fall under HUD's Homeless Definition.

Documentation of Homelessness

Documentation that supports an individual's homeless status must be kept and filed in the case record for each participant. HUD has outlined the recordkeeping requirements that are based on the four (4) categories of homelessness (see Appendix B). ***Questions regarding the definition or documentation of homelessness should be addressed to the local Continuum of Care Planning Body or regional HUD office.***

Referral Process

HUD requires the Continuum of Care Planning Body to develop a Coordinated Entry process, which standardizes the way homeless individuals and families access housing/homeless services, to include assessments, referral processes, and linked supportive services. CoC Rental Assistance Providers are encouraged and should be active members of their local Continuum of Care Planning Bodies, as well as work in conjunction with the Continuum of Care's Coordinated Entry process when considering referrals to their housing programs.

Day-to-Day Program Operations

Occupancy Agreement

Upon admission, the Permanent Supportive Housing Provider must review, and have program participants sign an Occupancy Agreement that outlines and specifies program expectations. The Occupancy Agreement also specifies what is required of participants to sustain their apartment occupancy. The Occupancy Agreement should include a provision that program participants agree to develop Service Plans with their Case Manager/Housing Counselor, and to work on achieving the goals and objectives they identified in their person-centered individualized plans. The Occupancy Agreement must be reviewed and renewed on an annual basis. **For the NY/NY III Population G (Chronically Homeless Families) Providers that have chosen the Two-Phase housing process, with participants still residing in scatter-site units, the Occupancy Agreement should include the agreement and understanding that the family will be required to move into the congregate building upon completion.** See Appendix B for a sample form.

Consent Forms

Consents must be signed prior to any potential contact(s), or requests for information by the Provider agency. This may include but is also not limited to participants' Health Home and Care Coordinator/Manager, a Substance Use Disorder and/or Mental Health treatment program. Parole or Probation Officers, and the person(s) to contact in case of an emergency. As previously mentioned, for admissions into the MRT program, Providers must **include** the OASAS consent form TRS-60; "Consent to Release of Information Concerning Chemical Dependence Treatment for Permanent Supportive Housing" (see Appendix B).

Mainstream Benefits

An important outcome of the Permanent Supportive Housing program is assisting participants in acquiring benefits and opportunities that would increase their options and resources, as well as potentially support their transition into gainful employment and/or vocational preparation. Each participant, when applicable, must also be linked to all available sources of income, including Public Assistance, DSS benefits, food stamps (SNAP), SSI, SSDI, etc. Many program participants will need assistance and support in keeping those benefits active, and complying with any county or city eligibility requirements, scheduled hearings, and/or appointments. Assisting participants in the attainment of entitlements and social services is a viable and at times necessary component

of any Permanent Supportive Housing initiative, as Providers should seek opportunities to manage the program without a budget deficit.

For participants who have exhibited great difficulty with budgeting and meeting financial obligations, a Rep-Payee is a viable recommendation, and should be an option discussed and offered as a solution.

Charting and Documenting Participant Progress

Supportive Services

Providing appropriate housing counseling services and other needed supportive services are essential to helping program participants maintain housing stability and attain self-sufficiency. Supportive services should be developed and coordinated by the Case Manager/Housing Counselor, in conjunction with program participants. Supportive services can be provided directly by the PSH Provider and/or through a Memorandum of Understanding (MOU) with other community-based organizations. Those supportive services in the community can include, but may not be limited to; Outreach, Case Management, Crisis Intervention, Outpatient or short-term Inpatient substance use disorder treatment, Outpatient treatment for mental illnesses, Outpatient medical care, Vocational/Educational services, Child Care and required transportation.

It is expected that participants' service needs will change and evolve over time. Ongoing assessment and re-evaluation are essential to meeting program participants' needs and providing the most viable and appropriate services. Information sharing between Case Managers and participants' Housing Counselors can help to develop, and revise Service Plans to establish achievable goals, review participants' progress, and update objectives as required and indicated. Additionally, whenever possible, Case Managers and Housing Counselors should seek to initiate or participate in participants' Case Conferences with their linked community-based service providers, to include but not limited to Health Homes, if indicated SUD treatment providers, family counseling services, etc. Those service collaborations with program participants helps to maintain/address their Service Plan objectives, ensure for continuity of care, and guard against duplication of services.

Among those difficult to serve populations, the mastering of basic tasks and skills can be a viable measure of their progress and should be viewed as positive successful outcomes for the

participant and Provider. Incentive Programs and interventions meant to motivate participants can be supportive of the desired changes and assist in overcoming barriers to improvements.

Case Notes

Case note documentation in participants' Case Records needs to begin upon admission to the housing program and should document all interactions between participants and program Case Managers/Housing Counselors, to include, Service Plans, the progress, and any updates. The length of time spent meeting with program participants should also be recorded. Case notes need to capture pertinent and salient information regarding participants' experiences and progress in the housing program. That would include but may not be limited to what supportive services the individual/family is receiving, any additional stressors they may be experiencing, what goals have been accomplished and/or modified (recorded) in participants' Service Plan, and any other information germane to participants' involvement in the housing program.

The Case Manager and/or Housing Counselor is usually the first person who will recognize the warning signs of; stress, inability to adjust/reintegrate into the community, and/or the warning signs of potential relapse back to prior ineffective behaviors, to include, alcohol and other drug use. Moreover, when applicable, the Case Manager, Housing Counselor, or a peer advocate should attempt to engage and refer participants, who may desire to participate in a recovery process, to the appropriate service provider. Those recommendations and observations should be identified and addressed by participants' Housing Counselors and Case Managers. What is equally important is for the housing program staff to record and document, in the case record, those event(s) and any outcome.

The target population for these programs may initially require intensive services. It is expected that within the first several months of residency, Case Managers/Housing Counselors would conduct more frequent home visits with an eventual adjustment of home visit frequency based on the needs of the individual/family. As participants progress and begin to demonstrate the ability to manage their responsibilities, the regularity of home visits should decrease.

Participant case note documentation supports and illustrates the work of Case Managers/Housing Counselors, Vocational Counselors, Program Directors, etc. During site visits and program reviews, OASAS will evaluate the services participants receive, as well as the quality and

effectiveness of Case Manager/Housing Counselor tenant interventions and the case record documentation.

Case notes must be detailed, and should address the following areas:

Observations: – participant's maintenance of self and the apartment unit.

Appointments: – Compliance with all appointments (e.g., medical, treatment, psychiatric). Documentation should also include any outcomes and/or recommendations from those appointments, as well as when indicated updates regarding the status of Health Home participation and if applicable HCBS services.

Stability: – A primary goal of all permanent supportive housing programs is to have participants achieve and maintain housing stability. Affordable and safe housing is important to the well-being and health of individuals and families. Documentation should address participants progress towards overall stability and attaining self-sufficiency.

Assistance: – What resources and/or assists have been provided/offered by the Case Manager/Housing Counselor, to include participants' responses and decisions.

Service Plan and Updates – What progress have participants made related to their person-centered individualized Service Plan goals, as well as service plan outcomes and updates.

Finally, the Case Record and its documentation supports and verifies the services and activities Providers are delivering. It is important that Providers ensure for regular and appropriate documentation of individuals'/families' participation in their housing program.

Service Plans and Updates

Service Plans should include clear and attainable goals that participants develop in conjunction with their Case Manager or Housing Counselor. The Service Plan should be Person-Centered and individualized. Service Plan goals should be specific to participants' overall wellness and working towards sustaining their housing. Those goals could include but may not be limited to community reintegration, family reunification, nutrition, physical exercise, budgeting, attainment of social service supports/entitlement benefits, motivation to address alcohol and other drug use, and the development of positive support systems. When applicable, specific interventions and Incentive Programs integrated into the Service Plan (e.g., Contingency Management, Motivational Interviewing), should be noted and recorded. The initial Service Plan should be completed within 30 days of admission, with reviews, progress updates, and Service Plan enhancements occurring quarterly (every three (3) months) in conjunction with the participant.

Please note that the first quarterly Service Plan review should take place within 90 days after admission. Quarterly updates of the Service Plan should be documented in the Case Record and Providers may use the Residential Functional Assessment Form to capture the Service Plan updates (see Appendix B). It is expected that all Service Plans are revised annually to reflect participants' progress in the program.

For programs that serve families, the Service Plan should focus on the entire family and when applicable include appropriate child specific goals. For families with minor children, there must be a documented plan in the Case Record for when the parent, guardian, and/or head of household must leave the home due to inpatient treatment, a hospitalization, incarceration, or some other event. That plan must specify where children will be placed and supervised during this absence from the home, as well as a plan for how rents and other financial responsibilities will be met. In addition, the housing program budget may be used to pay tenants' portion of their rent, for no more than 90 days.

Health Homes

Many people with chronic health problems are unable to find medical providers and services, which as a result, makes it hard for them to stabilize their health and well-being, as well as maintain a healthy lifestyle. New York State's Health Home program was created to support Medicaid beneficiaries, with chronic conditions, receive the medical care needed. A Health Home is not a physical location but a collaboration of healthcare and service providers working in partnership to ensure individuals get the physical and behavioral healthcare services they need. Once enrolled in a Health Home, individuals will have an assigned Care Manager/Coordinator who will work with them in the development of a viable and efficacious care plan. Case Managers and Housing Counselors with a release of information, should communicate with the Health Home Care Manager/Coordinator to ensure program participants' Service Plans are appropriately coordinated, and that individuals receive the necessary services to maintain their health and avoid unnecessary emergency room visits and hospitalizations. It should be noted that in some cases the Health Home Care Manager/Coordinator is also the Housing Counselor/Case Manager that is linked to the PSH program.

Employment

Providers of permanent supportive housing must assist program participants directly, or through linkages, in accessing services and resources that will enhance their ability to secure gainful employment, which may include identifying educational or employment opportunities, vocational training, developing employment readiness skills, and assisting in learning how to maintain employment (job retention). Job readiness should include the development of skills such as developing a resume, using internet employment search engines, and interviewing skills. Providers may also want to address aspects of employment marketability, which could include participant motivation, physical presentation/appearance, and other aspects of employment interviewing. Participants' educational background can at times be a good indicator of the types of educational services needed, as well as any literacy concerns that would influence the type of jobs being sought.

Tenant Rent Calculation and Income Recertification

Providers are expected to calculate the tenant's share of the rent based on the participant's annual income. Annual income includes payments from all sources, received by all members of the family who are not minors. The following types of income must be reported and factored into participants' rental obligation; gross income before payroll deductions, any overtime pay and tips; Social Security Disability Income (SSDI); Supplemental Security Income (SSI); pension benefits; Temporary Assistance to Needy Families (TANF); public assistance; unemployment benefits; workers compensation; and any interest, dividends, and subsistence payments to full-time students or veterans.

To determine the appropriate rent payment for a participant, Providers should complete a Program Participant Rent Calculation Worksheet (see Appendix B). The initial rent calculation should include at least two (2) bi-weekly or four (4) weekly pay stubs, a SSI/SSDI letter, or public assistance budget sheets. These documents should be kept on file along with the rent calculation worksheet in participants' Case Record. All participants in permanent supportive housing programs qualify for the $400 Disability Deduction, that should be entered on Line 14 of the Worksheet. PSH program staff must re-examine participants' income at least annually and make any needed adjustments to participants' rent contribution. ***Participant's income should be recertified when there is a decrease in household income, or if the source of income changes (i.e., resident becomes employed and is no longer receiving Public***

Assistance/DSS benefits). Participants whose income increases during the year do not have to have their rental obligation increased until the next scheduled (annual) recertification.

Participant Involvement

Providers are encouraged to fully involve participants in the operation and evaluation of the program. OASAS encourages and recommends the formation of Tenant Associations, with space made available for those meetings. Tenant Associations can motivate and inspire program participants to take an active role in the development of program policies and procedures, as well as enabling a place where participants can come together and support each other. Tenant Associations also enables individuals and families in giving valuable feedback regarding the needs of program participants.

Program Administrative Responsibilities

There are a variety of administrative tasks associated with operating an OASAS Permanent Supportive Housing program (PSH). It is important that Providers carry out these tasks effectively to ensure that the housing program runs smoothly; and is in compliance with all expectations and requirements.

Program Staff Responsibilities

Agency executive staff are ultimately responsible for ensuring that the PSH program operates in compliance with their OASAS contract. Program Directors need to ensure that Clinical Supervision for Case Managers and/or Housing Counselors are conducted and documented with regular reviews of participants' charting and maintaining the Case Record.

Monthly Reports to OASAS

Housing Providers are required to submit data and reports to the OASAS Housing Bureau each month. While the information may vary depending on OASAS' priorities and the brand of housing initiative, (e.g., the MRT program has monthly Medicaid data sharing requirements with NYS DOH) OASAS has standardized the monthly reporting forms and documents, which includes:

Program Report

- Project Progress and Occupancy Rates
- Admissions and Discharges
- Length of Stay
- Employment, Educational, and/or Vocational updates
- Participant Achievements
- Staff Changes
- Issues or Concerns
- Tenant Meetings
- Volunteer Activities
- Status of Monitoring Report

Monthly Rental Statement

(NOT required for the CoC Rental Assistance Program)

- Apartment Address
- Base Rent
- Program Participant's Share of the Rent
- Program Participant's Source of Income

Medicaid Data Collection – ** For MRT PSH Providers ONLY **

Collection of Medicaid data applies only to MRT PSH Providers. Part of the MRT program's intent and focus is the reduction of costly Medicaid services, as individuals are housed in affordable apartment units with supportive services and linked to Health Homes where they can address their physical and behavioral health issues and concerns. It is expected, and initial research/evaluations have shown how MRT subsidized permanent supportive housing has had a positive impact in reducing costs, as well as individuals' patterns and trends regarding the use of Medicaid benefits. Providers must ensure that all appropriate Release of Information documents

have been signed and dated. Providers must also report the Medicaid ID numbers of new admissions and discharges to OASAS on a monthly basis. Housing Bureau staff directly contact MRT Providers to ensure that Medicaid information is protected and obtained in a secure manner. OASAS is responsible for transmitting MRT participants' information and program data to the New York State Department of Health.

Incident Reporting

Providers should notify the Housing Bureau of any untoward incidents or the death of a program participant within 48 hours. Based upon the incident, further notification and/or documentation may be required. In addition, in accordance with Part 836 – Incident Reporting in OASAS Certified, Licensed, Funded, or Operated Services, an Incident Report must be submitted to OASAS' Bureau of Patient Advocacy (PatientAdvocacy@oasas.ny.gov), with a copy sent to the Housing Bureau.

Moving On and Program Discharge Planning

Termination of Assistance

Housing Providers may terminate an individual's participation in the PSH program if he/she violates program requirements or conditions of their Occupancy Agreement. Providers must exercise good judgment and examine all extenuating circumstances before determining when violations are severe enough to warrant termination from housing services. Terminations and/or evictions should happen only in the most severe or extreme cases, and after every effort by the Provider to resolve the matter and sustain the individual or family's housing.

Providers may retain an apartment for up to 90 days for individuals who are receiving inpatient care or are incarcerated. Providers should make every effort to maintain contact with the participant during their time away from the housing program, to include, when applicable, being in contact with clinical staff and criminal justice representatives. Providers may also terminate a program participant who has been lost to contact for a period of more than 30 days.

Due Process

In terminating an individual's participation in the housing program, the Provider must ensure for a formal process that recognizes the rights of individuals receiving assistance and follow due process of the law. This process, at a minimum, must consist of:

- Written notice to the participant containing a clear statement of the reasons for termination;
- An objective review of the termination decision, with program staff not involved in the termination decision, which gives the participant an opportunity to present written, oral, or witness objections to their dismissal from the program;
- Prompt written notice of all final decisions are given to the participant.

All aspects of the due process must be documented in the participant's chart.

Moving to Unsubsidized Housing

The goal of the any PSH program is to assist and support participants in their achievement of housing stability, increasing their skills, acquiring employment; obtaining greater self-sufficiency, and decreasing their risk for a return or relapse back to homelessness. With the aid and assistance of housing program staff and supportive services, Providers will at times find that some participants reach a point where they are ready for more independence and may no longer be in need of the services provided through the PSH program. For some of those individuals and families, alternative sources of permanent affordable housing may be more appropriate, or preferred. Assisting individuals and families in their transition to alternative housing arrangements, as they become more self-reliant and responsible, can support and increase self-esteem, while attaining self-sufficiency, and ultimately provides apartment units with subsidized rental assistance for new participants.

Turn-key

Turn-key is a way to move from subsidized to unsubsidized housing without needing to move from the apartment unit. The process is worked out with the specific landlord so that the participant takes over responsibility for the apartment lease. When a turn-key occurs, the Provider should locate

an additional apartment so that another eligible participant may be admitted to the program. Providers should remember that they are responsible for maintaining the number of housing units they have been awarded and contracted for with OASAS.

Documentation of Discharge

In cases of discharge, Providers are expected to fully document the events which led to the participant's departure or dismissal from the program. A Discharge Form should be completed either directly before, or directly after, the discharge depending on the circumstances. A written summary should capture and describe the reason(s) for discharge, employment status, recovery status, service referrals, and living situation to include the individual's or family's destination post discharge. Providers should offer each participant or family the opportunity to complete a Tenant Satisfaction Survey. Surveys should be maintained on file for OASAS' review. See Appendix B for samples of these forms.

Site Visits

OASAS Housing Bureau staff conduct routine site visits of permanent supportive housing Providers to ensure that their agencies/programs are operating in accordance with the Housing Bureau Guidelines. The OASAS Housing Bureau will notify agencies, in advance, when a site visit is being scheduled.

What to Expect During a Site Visit

Site visits consist of a program review. The program review includes an assessment of program participant files, with a focus on, admission criteria, Service Plans, documented case notes, inspections of housing units, and interviews with program participants and the Case Managers. In advance of the site visit, the OASAS Housing Bureau will randomly select files and apartments for review and unit inspection. OASAS may also review administrative items, including but not limited to, policies and procedures, staffing patterns, staff training, and program/staff supervision.

Exit Interview

An exit interview will take place at the end of the site visit. During the exit interview, OASAS Housing Bureau Associates and the provider agency will discuss results and outcomes from the site visit. A report summarizing the site visit will be issued to the provider agency, usually within 45 days. Any findings that are identified in the site visit report must be addressed by the Provider

through a Corrective Action Plan. The Corrective Action Plan must be submitted to OASAS within 30 days of the issuance of the site visit report.

Conclusion

OASAS and the Housing Bureau considers all housing agencies and Providers as partners in the goal and endeavor of reducing chronic homelessness. Moreover, while ensuring for quality of care and appropriateness of services, OASAS helps individuals and families become emotionally, behaviorally, and economically self-sufficient. The OASAS Housing Bureau is available as a resource to provider agencies and their housing program staff to answer any questions and provide technical assistance as needed.

Appendix A – Program Participant Chart Set-up

Model forms are available for your convenience and may be found on the OASAS website. Providers may use their own forms or revise the model forms, as long the revisions include all elements of the model forms. See Appendix B for links to the Model Forms.

Charts should include the following information:

Intake Information
Referral Form - with documentation to support eligibility
Intake Form
Participant Occupancy Agreement (initialed, signed & dated)

Apartment Information
Current and Past Leases with Landlord (signed, dated)
Initial Housing Quality Standards Inspection
Annual Housing Quality Standards Re-inspections/Updates/Repairs

Service Plan and Quarterly Updates
Participant Service Plan Form
Quarterly Service Plan Review

Progress Notes
Participant Progress/Case Notes
Incident Reports regarding behavioral or legal issues
Case notes
Discharge Form
Tenant Satisfaction Survey

Financial Information
Initial Program Participant Rent Calculation Worksheet & Income Verification
Annual Program Participant Rent Calculation Worksheet & Income Verification
Miscellaneous information about financial obligations, such as child support, credit card debts, loans, etc.

Releases
Consent for next of kin and in case of emergency contacts
Release and consent forms
Release of Information as needed (i.e. DSS, doctors, therapists, other human resource agencies, etc.)

Correspondence
Correspondence to or from participants – including rent arrears letters
Correspondence to or from outside parties

Appendix B - Model Forms and Other Resources

MRT PSH Referral Form

MRT PSH Intake Form

MRT Housing Consent Form (TRS60)

NY/NY III Intake Form

PSH Occupancy Agreement

PSH Intake Form

Housing Quality Standards Inspection Form HUD-52580)

Furnishings and Equipment Inventory Form

Sample Supportive Services Plan

Residential Functional Assessment Form (NYSCRI Form)

Tenant Rent Calculation Worksheet

Discharge Form

Tenant Satisfaction Survey

Resources for Continuum of Care Program

HUD's Homeless Definition

HUD's Recordkeeping Requirements