Housing Services Standards

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,6 although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards. Housing, as described here, replaces PCN 11-01.

Virginia Ryan White Part B Service Unit Definition:
One initial individualized housing plan; one annual individualized housing plan update; one month's rent; one month's utilities; (**or**) one navigation service effort (search, placement, advocacy, referral, housing service coordination, inspection).

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health Service Standards for people with HIV, including the following:

1.0 Intake and Eligibility

As outlined in HRSA HIV/ AIDS bureau (HAB) Policy Clarification Notice (PCN) 21-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. HIV Status: A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02.

2. Low- Income: The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which is measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. Residency: The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1.) Documentation of referral for Housing Services by a Part B provider prior to initiation of the service.	1.1) Documentation of referral for Housing Services is present in the client's record, signed and dated.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services is determined. To be eligible for this service applicants must: a) Be diagnosed with HIV (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third party payers such as private and commercial	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their

insurance plans, and other payers that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures Part B services are used as the payer of last resort and other funding sources must be vigorously pursued**.** Client must agree to participate in the insurance option that the client is eligible for and that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the VDH PROVIDE data system.	medical needs and for which the client is eligible.
Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.
2.0 Key Services Components and Activities	
Standard	**Measure**
Documentation	
2.1) Documentation of mechanism to allow newly identified clients' access to housing services.	2.1) Documentation of process to access housing services for newly identified clients.

2.2) Provision of all housing services is documented by: • Number of clients served • Duration of housing services • Types of housing provided • Housing referral services provided • Assistance provided to help clients obtain stable, long-term housing • Assurance that no Ryan White funds were used to provide direct payments to clients for rent or mortgages.	2.2) Documentation of housing services provided.
2.3) Client records must contain, at a minimum: • Housing and referral services provided • Individualized written housing plans that are consistent with RWHAP' s Housing Policy • Individual service plan must be updated annually • Assistance provided to clients to help obtain stable long-term housing • Method of providing housing services (e.g. payment to agencies). *Note:* Housing services cannot be in the form of direct cash payment to client and cannot be used for mortgage payments. Must sign and date all reports.	2.3) Signed, dated reports located in the client's record.
Assessment/Service Plan/Provision of Services	
2.4) Complete an initial assessment of client's housing needs within seven business days of initial contact with client and prior to the provision of service. A triage process needs to occur to determine if emergency housing is needed.	2.4) Documentation of assessment in client's record signed and dated. Develop individualized written housing plan within 48 hours of initial assessment.
2.5) Within seven (7) business days after the initial assessment, develop an individualized written housing plan consistent with the	2.5) Documentation of housing plan in client's record signed and date.

RWHAP Housing Policy. The housing plan is designed to help the client obtain or transition to stable long-term housing, through a strategy to identify, re-locate, and/or ensure the individual or family is moved to or capable of maintaining a stable long-term living situation.	
2.6) Individualized housing plan is reassessed quarterly or at a minimum every three months to determine the need for new or additional services.	2.6) Documentation of housing plan reviewed and revised quarterly or at a minimum every three months in client's record signed and dated.
2.7) Housing-related referral services may include: • Housing assessment • Search, placement and/or advocacy • Fees associated with any of these activities.	2.7) Documentation of housing-related referral services provided to enable the client or family gain or maintain outpatient/ambulatory health services and treatment.
2.8) Housing Services provide time-limited transitional, short-term, or emergency housing assistance. Eligible housing can include either housing that: • Provides some type of core medical and/or support services (such as residential substance use disorder services or mental health services, residential foster care, and assisted living residential services); or • Does not provide direct medical or support services, but is essential for a client or family to gain or maintain access and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.	2.8) Documentation of necessity of housing services for purposes of medical care in client's record signed and dated.
2.9) Housing funds may be used for application fees and rent payments. VDH approved duration of housing services includes: • Emergency Housing 1-14 days	2.9) Documentation of housing assistance type provided within defined limits in client's record.

• Short term Housing 15-30 days • Transitional Housing 31 days to 24 months.	
Transition and Discharge	
2.10) Client discharged when Emergency Housing Services are no longer needed, goals have been met, upon death or due to safety issues. (*see 2.11*) <u>Prior to discharge</u>: Conduct discussion with client over reasons for discharge and options for other service provisions. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to client's last known address. If client is not present to sign for the letter, return to the provider. **Exception: If the client has noted during the intake or at any other time to the VA MAP staff that sending mail is not permitted, no letter will be sent. If this is the case, VDH will document this in progress notes and discharge summary.* <u>Documentation:</u> Client's record must include: a) Date services start b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable. <u>Transfer:</u> If client transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location.	2.10) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter*, if applicable. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* Discharge summary and other records send with the patient

Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state case closure within 30 days from the date on the letter if no appointment is schedule with the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* Withdrawal from Service: If client reports no longer needing services or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge and notify of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources	Document attempts made

must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	
Case Closure	
2.11) Case will be closed if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the housing assistance staff for a period of three months despite three (3) documented attempts to contact client; g) Can no longer be located; h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits pattern of abuse as defined by agency's policy. j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or k) Is deceased.	2.11) Documentation of case closure in client's record with clear rationale for closure.

3.0 Client Rights and Responsibilities	
Standard	**Measure**
3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the American's with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering service on the basis of the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or AIDS/HIV diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	3.1) Written eligibility requirements and non-discrimination policy on file.
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they have been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy.	3.2) Written policy on file.
3.3) Provide explanation of *Client's Rights and Responsibilities* to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• Be informed about services and options available; • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone; • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. Client responsibilities include: • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible, phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number, respond to phone calls and mail and • Avoid subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	
4.0 Grievance Process	

Standard	Measure
4.1) Grievance policy exists which requires each client to sign and date indicating they have been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and c) communication of client's understanding of the policy. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.
4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, if they have any complaint, or concern about the services received	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status, and resolution.
4.4) Review of grievance policy yearly with client signature.	4.4) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's grievance procedure.
5.0 Personnel Qualifications (including licensure)	
Standard	**Measure**
5.1) All staff who provide Housing-related referrals will be case managers or other professional(s)who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs	5.1) Documentation of qualifications in personnel file.

5.2) All housing staff must complete six (6) hours of continuing education in HIV/AIDS annually.	5.2) Documentation of continuing education credits in personnel file.
6.0 Cultural and Linguistic Competency	
Standard	**Measure**
6.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual, or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	6.2) Culturally and linguistically appropriate materials and signage accessible.
7.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	7.1) Written Client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information if applicable.	7.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration

	of not more than 12 months from date of signature.
7.3) Store each client's file in a secure location with electronic client records protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access is limited to appropriate personnel.
7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
8.0 Quality Management	
Standard	**Measure**
8.1) Measure and report client health outcomes using Housing Services measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Housing Services, regardless of age, who will have at least two care markers in a 12-month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program living with HIV and receiving Housing Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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