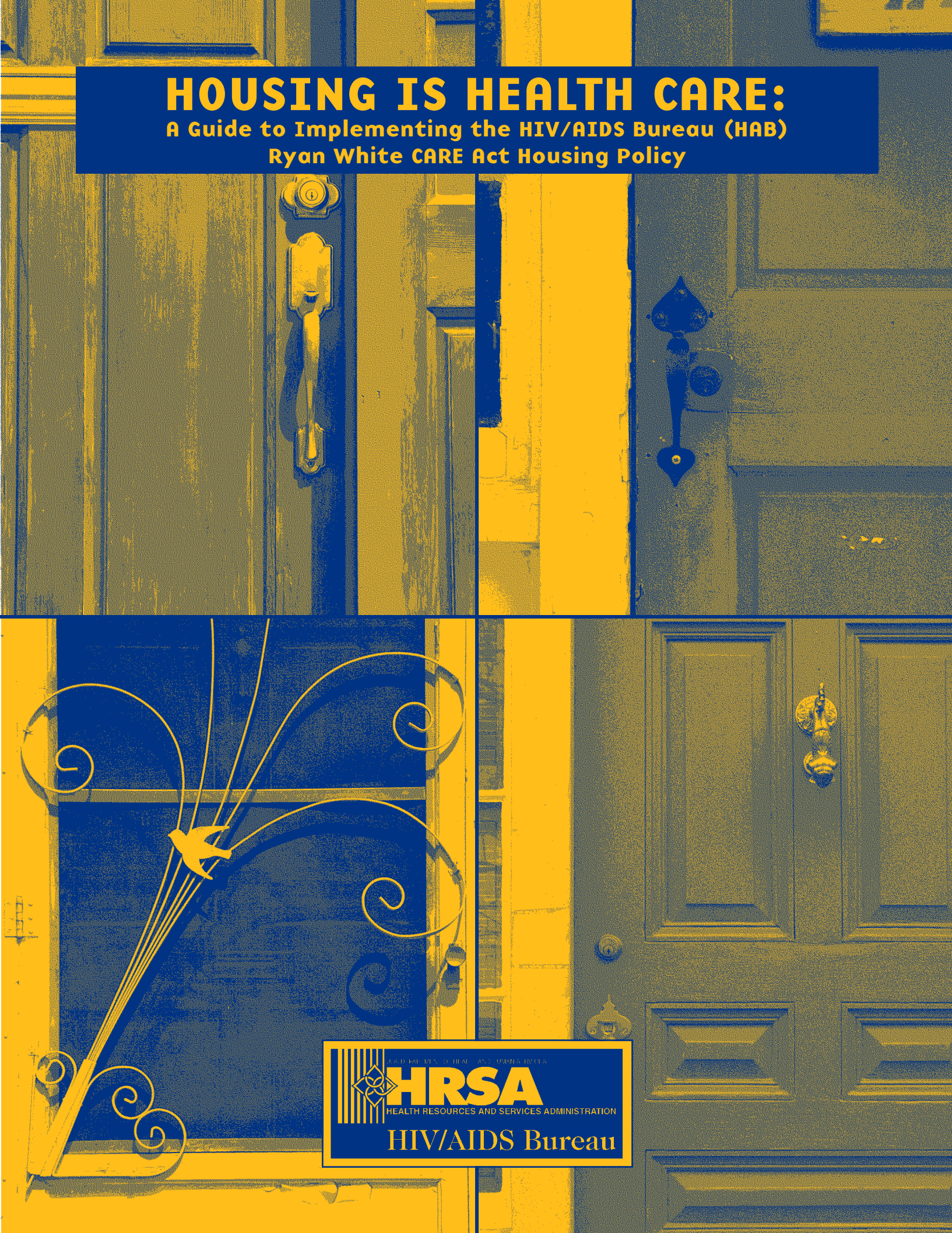

HOUSING IS HEALTH CARE:

A Guide to Implementing the HIV/AIDS Bureau (HAB) Ryan White CARE Act Housing Policy

HRSA
HEALTH RESOURCES AND SERVICES ADMINISTRATION
HIV/AIDS Bureau

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Introduction

The CARE Act and Housing Assistance

Significant Federal funds are expended through multiple agencies to provide housing-related assistance to people living with HIV/AIDS (PLWH). The bulk of Federal housing-related resources are awarded through the U.S. Department of Housing and Urban Development (HUD). Additional funding is provided under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which funds primary care and supportive services–including housing-related expenses–for under-served individuals living with HIV/AIDS.

The purpose of this Guide is to provide guidance on funding of housing-related costs under the CARE Act. In particular, the Guide focuses on implementation of HAB Policy 99-02, as issued in 1999 by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), which administers the CARE Act.

This guide has three purposes:

1. To clarify expectations of the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) regarding the implementation of HAB Policy 99-02 on the use of CARE Act funds for Housing Referral Services and Short-term or Emergency Housing Needs;

2. To assist CARE Act grantees, and their planning bodies and contractors, in developing effective implementation strategies in compliance with the policy; and

3. To provide information about the national context in which CARE Act-funded AIDS housing programs operate and about resources that grantees and others may use to adapt and strengthen AIDS housing programs using the new housing guidelines.

CARE Act Housing-related Expenditures

Titles I, II, and IV of the Ryan White CARE Act allow housing-related assistance as eligible expenditures. In FY 1999, an estimated $40 million was proposed for housing services by CARE Act grantees.

- **Title I fiscal year (FY) 1998 grant applications show that 38 of the 51 Title I EMAs proposed $38.2 million in housing and housing-related service activity, or 7.2 percent of available Title I dollars.**
- **Forty percent of Title II grantees reported housing expenditures in FY 1998.**
- **Eligible metropolitan areas (EMAs) report that 14 percent of their populations are affected by homelessness.**
- **Eighty-seven percent of EMAs report some degree of coordination with local HOPWA programs.**
- **Thirty-seven percent of EMAs conduct housing assessments as part of their needs assessment process.**[1]

The Guide's primary target audience is grantees under Titles I, II, and IV whose legislative authority allows for funding of housing-related expenses. Other CARE Act programs can also benefit from a review of this guide given that agencies often receive funding from multiple sources and need to be informed of requirements across the CARE Act. As CARE Act programs address an array of primary care and support service needs of PLWH, HAB's goal is to ensure that CARE Act resources do the following:

- serve as a payer of last resort, as called for in CARE Act legislation;
- are utilized in a coordinated fashion with other funds; and
- do not supplant funds from such other sources as HUD's Housing Opportunities for Persons with AIDS (HOPWA) program.

[1] Information presented at September 1999 HOPWA Grantees Meeting in Baltimore, MD, by HRSA staff.

HAB Policy 99-02

The Use of Ryan White CARE Act Funds for Housing Referral Service and Short-term or Emergency Housing Needs

The following policy establishes guidelines for allowable housing-related expenditures under the Ryan White CARE Act. The purpose of all Ryan White CARE Act funds is to ensure that eligible HIV-infected persons and families gain or maintain access to medical care.

A. Funds received under the Ryan White CARE Act (Title XXVI of the Public Health Service Act) may be used for the following housing expenditures:

   I. Housing referral services defined as assessment, search, placement, and advocacy services, which must be provided by case managers or other professionals who possess a comprehensive knowledge of local, State, and Federal housing programs and how they can be accessed; or

   II. Short-term or emergency housing defined as necessary to gain or maintain access to medical care, which must be related to either:

      a. housing services that include some type of medical or supportive service: including, but not limited to, residential substance abuse or mental health services (not including facilities classified as an Institute of Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or

      b. housing services that do not provide direct medical or supportive services but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. Necessity of housing services for purposes of medical care must be certified or documented.

B. Short-term or emergency assistance is understood as transitional in nature and for purposes of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation.

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

D. The Ryan White CARE Act must be the payer of last resort. In addition, funds received under the Ryan White CARE Act must be used to supplement but not supplant funds currently being used from local, State, and Federal agency programs. Grantees must be capable of providing the HIV/AIDS Bureau with documentation related to the use of funds as payer of last resort and the coordination of such funds with other local, State, and Federal funds.

E. Ryan White CARE Act housing-related expenses are limited to Titles I, II, and IV and are not an allowable expense for Title III.

Housing and the CARE Act: Policy in the Context of Today's Epidemic*

Dr. Joseph O'Neill

Associate Administrator, HIV/AIDS Bureau (HAB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS)

Most of us remember our first contact with HIV / AIDS. Mine was in 1983 at San Francisco General Hospital. I was a medical student at UCSF, and I cared for a young, white, gay man. I remember him very clearly. He was admitted to the hospital with a fever and an infiltrated pneumonia. He was quite sick, and we didn't know what he had.

He died within 24 hours of admission, an uncomfortable respiratory death. We didn't know how to treat what we now know to be pneumocystis. Today, I would treat him as an outpatient and would have little problem sending him home with a prescription for Bactrim and a follow-up appointment the next day in clinic.

I remember him so clearly. I remember his name, what he looked like, what his hopes and aspirations were; and I remember what it felt like to have him die. I know that had he been with us now and able to access today's medical care, he would be alive.

It is so easy for us to concentrate on how much we don't know, on the many failures of policy, the failures of compassion, failures of intellect that we face in dealing with this epidemic. But we've also done some things right. We've come a long, long way, and it's important for all of us to take a minute to reflect on that.

Those of us who are still active in this arena are going to be judged not only on what we did back then, but also by what we're doing right now, by how well we respond to the changes in the epidemic and the changes in care and services. Let me talk about what these changes should be and what's happened since 1983 and my first AIDS patient.

HRSA's Four Principles to Guide CARE Act Programs

The Health Resources and Services Administration's (HRSA) goal of "100% access, 0 disparity" is to increase the focus of HRSA programs on achieving access to high quality health care and eliminating race, gender, and geographic disparities. Supporting this goal are the following HAB principles with implications for HIV / AIDS services in thecoming years:

1. **The HIV/AIDS epidemic is growing among traditionally underserved and hard-to-reach populations.** The previously unseen faces of those with HIV / AIDS are becoming more apparent. Communities of color, women, and substance users have always been part of the HIV / AIDS epidemic, but now what had been hidden is emerging. Systems of care and medical interventions have included primarily whites, and it is in that population that we have seen the most positive

* Modified from a speech originally printed in the *Third National HIV/AIDS Housing Conference Report*

health outcomes. But the HIV penetrating further and further into the most marginalized sectors of our society. And now nationally, and particularly through CARE Act programs, we are trying to take care of people whom society has traditionally ignored-homeless people, women who are dependent upon welfare, people with substance abuse problems, gay and bisexual men of color, and other communities that have been affected by HIV/AIDS.

AIDS has always been a disease that has financially devastated people, a disease that causes poverty. Today, it is increasingly a disease of poverty. That is an important distinction when we're thinking about constructing networks of services and support for people living with HIV/AIDS. Now we are trying to work with and in communities where basic pieces of infrastructure have never been adequately available. To build an HIV care system based on an existing health center or hospital that has been in a community for 25 or 30 years is one thing, but it is a very different challenge to try to build it from scratch, where there is nothing. And that is increasingly what we are doing.

2. **The quality of emerging HIV/AIDS therapies can make a difference in the lives of people living with HIV disease.** Medical care makes a difference for people living with HIV/AIDS in a way it never has before. We can provide therapeutics to people that will help them live longer and better lives. These are not cures, but they do have a significant and profound impact on longevity and quality of life. This is quite new. It means a mother will have more years with her child; a child will have more years with her parent. It means that someone may live long enough or be healthy enough to really tackle a substance abuse issue. It means that someone may be able to resume working. These are things that have come about because of our ability to provide high-quality medical care. Access to that care, however, is not evenly distributed in this society.

3. **Access to high-quality health care is not universal.** There has been a sort of tsunami effect of managed care and the way that we finance health care in this country. Welfare reform has had a huge effect in terms of people's access to Medicaid in many States. Until we, as a Nation, get it clear that access to high-quality health care is a basic human necessity, we are going to have to continue with this complex, convoluted, patchwork approach. All of us, I think, are striving to get beyond the present system, but the reality of today's health care marketplace must be incorporated into our programs and policy.

4. **Policy and funding are increasingly determined by outcomes.** We are trying to provide these services in a political climate that is very different from that of 1983. We have to reframe our thinking and do a much better job of identifying the outcomes of our programs and policies. We can no longer appeal only to compassion as a means of advancing social policy; we have to be able to describe the impact of what we do. We have been working very hard at HRSA in our data collection, evaluation, and analytical activities to demonstrate what we know to be true-that people's lives and health depend on the activities we support.

The impact of these four changes is huge. People's lives are in the balance here. We are dealing with whether people live or die.

Key Questions for the Future

Reauthorization of the CARE Act has happened. In that context, we have some very serious questions to ask as we look to the future. Are we supporting the right system of activities with these programs? I contend that if we are still supporting the activities we were 10 or 15 years ago, then we are not adequately attending to the four changes listed above.

Remember that the CARE Act system developed in a time when clinical treatment had little impact on health outcomes. Additionally, the changes in the demographics of the disease, the health care marketplace, and the political climate were not as dramatic as they are now.

As we look toward the future, consider the following: Are the configurations of our support services optimal? To what degree are we meeting the needs of emerging populations with the organizations and entities that we're funding now? How do we build the infrastructure and increase our capacity to deliver new medical treatments to people who have no access to health care? How do we do that in communities where even basic health care needs are not being met, let alone the sophisticated health services that are required with state-of-the-art HIV treatment? And, finally, how do we balance competing demands for pharmaceuticals and medical care with other essential services such as housing?

Local Decision-making is Crucial.
First, we need a heterogeneous approach to the implementation of policy. One of the wisdoms of the CARE Act is to have local autonomy over the lion's share of the money. It needs to remain that way. There is no one inside the Beltway who can figure out what Paducah, Kentucky, or Orange County, California needs as well as someone who is living in Paducah or Orange County.

Involve People Living with HIV.
Second, it is absolutely critical to actively involve people living with HIV/AIDS in planning and policy setting. We have to continue to recognize that we have an extremely diverse and very complex Nation. One of the great successes of the CARE Act has been its track record of local control, of diversity, of struggling with doing something good across this entire country.

A Comprehensive Definition of Health Care.
Finally, we need a much more progressive definition of health care. This is very important, so let me expand on it.

We have tended to buy into a paradigm that pits medical care and pharmaceuticals against social and support services. Everyone who has worked with planning councils has had to face this debate. This split denigrates housing, case management, and support services that

are absolutely critical to helping people maintain their health. These are real issues because ultimately economics, the dismal science of distribution of scarce resources, means hard decisions must be made. It is not helpful to continue to think that these services are conceptually opposed to one another. We need to reframe this debate.

We need to understand, for example, that the effective use of protease inhibitors mandates an effective housing policy. They are pieces of the same thing. When you seek funding for CARE Act services, you have to be able to justify the impact of spending money on housing, and other services. This requires as broad a definition of health care, like the one traditionally used by HRSA and used for 30 years by the Community and Migrant Health Center Program. Effective primary care has health care as its centerpiece, and social services, support services, and community outreach as part of an effective health care strategy and policy.

It is ridiculous to give $20,000 a year in medical prescriptions to someone who is forced to live under a bridge. We have to make the argument that housing is an essential piece of medical care. We must frame our definition of health care more broadly—what is, actually, a more traditional way, a way we have used for years at HRSA.

In recent years, there has been increased review of all our programs, examining them within the context of what was authorized in the CARE Act. Housing is one of those areas. Housing policy had not been clearly stated, and we struggled for a long time with how to issue policy guidelines in this area, be consistent with the Act—especially regarding not supplanting other sources of funding and other very clear statutory language—and not hurt anyone. Development of this policy was through a dialogue with our constituents, activists, Congress, our general counsel, and many others.

HRSA's goal was to craft the most flexible policy that is consistent with the CARE Act legislation. Although we are restricting the policy to transitional/temporary housing, we don't define "transitional/temporary." Because we don't know yet what the recent changes in medical treatment of HIV/AIDS mean to the evolution of the epidemic, it is foolish to adopt any definition of "short-term."

This policy makes the point that housing is an important piece of a health care system, and that it is justifiable in that it improves access to care and adherence to treatment—medical treatment and substance abuse treatment. HRSA cares about this passionately, and what we all want is to see CARE Act funding that continues for as long as it is needed.

Implementation of the HAB Housing Policy

The impact of the HAB housing policy will vary from community to community. Most areas use little of their CARE Act monies to fund housing services and have focused on emergency housing needs. Other areas, particularly those in very high-cost housing markets, have relied on CARE Act funds to provide significant support to their entire continuum of AIDS housing. All jurisdictions, however, will experience some impact from the HAB housing policy, including changes in record keeping and coordination with other housing funders and processes.

The HAB Housing Policy has three specific impacts on how jurisdictions may allocate and spend CARE Act funds for housing activities. Some communities must only be concerned with one, while others may need to make changes in two or all three areas. The impact areas are:

1. **Housing Categories to Use in the Allocations and Application Process** (page 9);
2. **Record Keeping and Documentation** (page 12), including:
   a. certification of need for housing services for purposes of medical care,
   b. long-term housing strategies for clients, and
   c. planning and coordination/payer of last resort; and
3. **Implementing Funding/Program Changes to Comply with HAB Housing Policy** (page 18).

Discussion on how to address these areas is presented in the following format:

- Table (requirements of policy and strategies for implementation)
- Text (detailed discussion of impacts and strategies)
- Examples (typical scenarios)

Following this chapter, HRSA's "Q & A on the Use of CARE Act Funds for Housing" is reprinted to answer specific questions regarding the policy.

In implementing the HAB housing policy, communities will be challenged to work creatively and cooperatively to ensure a smooth transition and to minimize displacement. Grantees, particularly in significantly impacted communities, should work closely with their HRSA project officer to develop appropriate implementation plans and time lines that move the grantee forward quickly and with the least disruption. The goals of the implementation plan should be a seamless transition for clients who currently rely on the CARE Act for support, and clear, simple guidance for providers who must implement the new reporting and documentation requirements. Grantees can take advantage of this challenge as an opportunity to assess the current housing services provided and develop greater collaboration across the HIV housing and services continuum.

Under the HAB housing policy there are two categories of housing-related expenditures to which CARE Act funds may be allocated: Housing Referral Services, and Short-term or Emergency Housing. In addition, CARE Act funds continue to be available for a variety of

HAB Housing Policy – Impact Area One:
Housing Categories to Use in the Allocation and Application Process

Requirement	Impact	Strategy/Solution	Who is Involved?
CARE Act funds for housing may only be allocated to the categories of housing referral services and emergency or short-term housing assistance. Funds may be separately allocated to a variety of support services categories.	Grantees, planning councils, or consortia may need to revise previous methods of describing current housing assistance activities to ensure all activities described in their CARE Act applications are represented correctly.	Grantees must ensure that applications to HRSA, local requests for proposals and contracts issued are consistent with activities occurring in the area and describe only allowable uses under the new housing policy.	Grantee, HRSA, planning council or consortium, housing providers.

health care needs and supportive services. These services may be delivered in many settings, including within housing programs. In this document, see charts on pages 10 and 22, respectively titled "Allowable CARE Act Expenses" and "Ryan White CARE Act and HOPWA Eligible Activities."

Housing Referral Services include assessment, search, placement, and advocacy services to assist persons living with HIV/AIDS to obtain and maintain stable housing. Housing referral services must be provided by case managers or other professionals who possess a comprehensive knowledge of local, State, and Federal housing programs and how they can be accessed.

To be funded by CARE Act funds, housing programs and assistance either must be emergency in nature, or short-term. Emergency assistance refers to programs or payments of very short duration that are intended to assist individuals or family households with immediate housing crises. Examples of emergency assistance include hotel or motel vouchers, emergency shelter placements, homeless prevention assistance such as one-time rent payments, assistance moving to a new location, and payments to cover bed nights in an emergency alcohol or substance abuse detoxification program. Housing funds may only be used for detoxification services if the provider agency requires payment for the housing portion of the program, and does not receive CARE Act funds from the substance abuse category to cover this expense.

Short-term assistance refers to programs or payments that are designed to stabilize an individual's housing situation, and to support his or her transition to a long-term sustainable housing situation without the use of CARE Act funds. Short-term housing includes transitional housing programs, short-term rental assistance, temporary assisted living, and short-term residential treatment. As with detoxification services explained above, CARE Act housing

← Allowable CARE Act Expenses →

Primary Medical Care, Emergency Assistance, and Supportive Services	Housing Assistance	
	Housing Referral Services	**Short-term or Emergency Housing Assistance**
• Primary medical care (e.g., drug therapies, substance abuse treatment, payment for emergency residential treatment/ detoxification, mental health treatment, nursing and attendant care, hospice services) • Support services that enhance access to care (e.g., case management, meals/nutritional support, transportation) • Other health and supportive services[2] • Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing, and referral	• Housing assessment, search, placement, and advocacy service (provided by professionals who possess an extensive knowledge of local, State, and Federal housing programs and how they can be accessed)	• Emergency housing assistance (hotel vouchers, homeless prevention, short-term rental assistance)· • Emergency shelter stays· • Temporary/ transitional housing programs • Short-term residential treatment· • Temporary assisted living

[2] The service category of "Emergency Assistance" (which falls under Supportive Services and Other Health and Supportive Services) cannot be used to fund housing referral and short-term or emergency housing services. Emergency housing needs must be funded under the category of "Short-term or Emergency Housing Assistance," described in this chart. However, other housing-related emergency expenses such as utilities can be included under the service category of "Emergency Assistance."

funds may only be used for residential treatment services if the provider agency requires payment for the housing portion of the program and does not receive CARE Act funds from the substance abuse category to cover this expense.

Title I, II, and IV grantees should allocate funds separately to emergency and short-term housing assistance subcategories.

Funds for operations and rental assistance for permanent housing are not allowable under HAB Policy 99-02. However, primary medical care and support services for residents of permanent housing are–provided that they meet HRSA definitions of allowable services and are funded out of primary medical care and supportive services categories, not out of housing assistance. For example, CARE Act funds cannot be used to fund the operations of an apartment building for people with AIDS, but the substance abuse services in that facility can be supported with CARE Act funds from the allocation under Substance Abuse Treatment. Operating costs of permanent housing will have to be funded by non-CARE Act sources.

In some communities, CARE Act funds have already been used in keeping with the HAB housing policy, but the way in which grantees have classified the housing services made it difficult for HRSA to determine whether these services were allowable. To ensure compliance with the HAB housing policy, grantees will need to carefully review how housing funds are allocated and described in their applications to HRSA and ensure that housing assistance categories and eligible activities are well understood within the community.

Example 1-Assisted living

Community A has described a temporary assisted living facility as permanent housing in its application to HRSA because there is no specified limit on the length of stay, despite the fact that residents are moved to lower levels of care as soon as they are able. This grantee will need to clarify that this type of housing is actually intended to be short-term, and must fund it out of the short-term housing assistance category. The facility operator will need to ensure that clients are linked to other long-term housing options, and that any clients who stay in the facility for an extended period are shifted to another funding source.

Example 2-Rental assistance

Community B uses the term "rental assistance" to describe a program that provides temporary rent payments to landlords on behalf of clients. The program is time-limited and focuses on clients becoming self-sufficient. In this community the grantee will need to ensure in its application to HRSA that it requests funds for this program in one of the two allowable subcategories: short-term or emergency assistance. HRSA does not require specific time limits for these two types of assistance, but does require communities to develop long-term housing strategies for clients.

Example 3-Linked to health care services

In Community C, appropriate short-term housing assistance is provided through vouchers and site-based programs. However, in the CARE Act application it appeared to HRSA that the housing assistance was not necessary to gain or maintain access to medical care. This occurred because the application did not describe programmatic links with services such as primary care, mental health treatment, case management, etc. The grantee in Community C should ensure that requests for housing assistance funds clearly describe links to other service categories.

Planning councils often set priorities for the allocation of funds to categories for application to HRSA. Consortia set priorities and may be involved in decision-making about the allocation of funds. Grantees develop the Federal applications and issue the funds to the community, often through a request for proposal (RFP) process. Grantees should ensure that the language they are using to describe housing assistance services in the HRSA application meets HAB housing policy definitions, and that their local RFPs clearly delineate eligible uses of funds and the documentation that providers must keep in order to receive the funds.

Housing assistance providers will need to understand the new terminology being used if it is a change from previous practice. Providers can be key sources of information for grantees and planning bodies (planning councils and consortia) to ensure that the services they actually provide are adequately described in the annual application process. In many communities, there is a public review of the CARE Act application before it is submitted. Housing services providers may want to review the information presented to ensure that it fits with what they understand based on the HAB housing policy and what they are actually providing.

The Ryan White CARE Act Amendments of 2000 expand planning council membership to include providers of housing and homeless services. This is in addition to a HOPWA representative who would fall under the "other Federal HIV programs." This new requirement is expected to help strengthen the link between planning for HIV care and housing.

HAB Housing Policy – Impact Area Two:
Record Keeping and Documentation

Requirement	Impact	Strategy/Solution	Who is Involved?
a) Certification of need for housing services for purposes of medical care. *Housing assistance with CARE Act funds must be essential to a client's ability to gain or maintain access to medical care or treatment.*	To provide a client with housing assistance, a housing provider must obtain written certification signed by a qualified professional which documents that housing assistance is essential to the client's ability to gain and/or maintain access to HIV-related medical care or treatment. Qualified professionals may include physicians, nurses, care coordinators and case managers. Grantees determine which qualified professionals are eligible to certify. Certifications must be periodically updated if the client continues to receive housing assistance.	Grantees develop approved format to certify medical need for housing, to be used throughout the area. Primary documentation should be kept in clients' files on site in at least one place in the CARE Act-funded network. Client files at every location should include primary documentation or reference to the primary documentation in the form of a certified referral form or a notation that eligibility for housing assistance has been confirmed.	Grantee, housing assistance providers, qualified professionals, care coordinators.
b) Long-term housing strategies for clients. *Strategy is required for all clients receiving housing assistance to ensure that the individual or family will be moved to, or capable of maintaining, a long-term, stable living situation without CARE Act support.*	Clients coming into CARE Act-funded housing assistance programs must work with the appropriate case manager, care coordinator or housing provider to develop a long-term housing strategy that identifies other sources of funding or housing resources to cover long-term housing needs. Housing strategies should be reassessed and modified at least every six months, and more frequently as needed, for as long as the client receives CARE Act-funded assistance.	**Strategy A: Standardized format** Community develops standard long-term housing strategy document for use by all case managers and other providers assisting clients with service planning. **Strategy B: Adapt existing service plans** Grantees review and approve current intake and assessment documents used by care coordinators/case managers to ensure that they include a long-term housing strategy.	Grantee, housing assistance providers, case managers, other services providers, planning council or consortium members. Grantee, case managers/care coordinators, housing assistance providers.
c) Planning and coordination/ payer of last resort. *Planning must be coordinated with other local, State and Federal funds and CARE Act funds must be used only as payer of last resort.*	Communities must be able to document coordination with other housing assistance funds and planning processes.	AIDS housing providers become involved in other planning processes for housing assistance to inventory and document availability of other housing resources in the community. Grantees describe coordination process in CARE Act application.	CARE Act grantee, HOPWA grantee, planning council or consortium, HOPWA planning body, AIDS housing providers, Consolidated Plan or Continuum of Care bodies, homeless coalitions.

Record Keeping and Documentation

To meet the requirements of the HAB housing policy, jurisdictions must be able to document that:

- the clients they serve require short-term or emergency housing assistance to gain or maintain access to HIV-related medical care and treatment;
- the assistance provided is not for permanent housing, and that strategies are in place to transition clients to a more long-term, stable living situation; and,
- CARE Act housing funds are used as funds of last resort and in coordination with other local, State, and Federal housing programs.

Certification of need for housing services for purposes of medical care

The grantee must have in place written procedures to ensure that the housing assistance provided with CARE Act funds is essential to a client's ability to gain and/or maintain access to HIV-related medical care or treatment. This need must be certified on an individual basis by a qualified professional who coordinates care for the HIV-positive individual, and may include physicians, nurses, care coordinators and case managers.

The grantee must establish a policy as to the form the documentation should take and the personnel eligible to certify clients' need. Grantees may choose to use a standardized certification form or a letter from a qualified professional.

Certification form: A standardized document that allows a care coordinator or other qualified professional to certify the client's need for housing assistance. This form should include language to certify that the client requires emergency or short-term assistance in order to gain and/or maintain access to medical care. It should also indicate whether the housing service to which the client is referred will include some type of needed medical or supportive service, or whether the housing service will allow an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. An example of this form is on the following page.

Letter from a qualified professional: This letter should be directed to the agency receiving CARE Act funds for housing assistance to which a client is referred. It should state the basis on which the qualified professional has determined that housing assistance is essential to the client's ability to gain or maintain access to care or treatment, and the type of housing for which the client is being certified.

Because the intent of the certification is to document the client's immediate need for emergency or short-term housing assistance, grantees must also have a process by which they will reassess the status of clients receiving housing assistance. If a client continues to receive housing assistance for a longer period than originally was anticipated, a reassessment and certification will be needed to support continuation of the assistance. The re-certification should occur at least every six months.

Grantees may wish to convene a meeting with care providers and housing services providers to describe the new requirement and to determine which method of certification is most suitable to the community. Grantees are also responsible for monitoring contractors for compliance with the policy and for providing technical assistance to contractors who may be having difficulty implementing the new documentation requirements.

Certification of Need for Housing Services for Purposes of Medical Care

The following is based on a form developed in Washington State which is used to document that the housing assistance provided with CARE Act funds is essential to a client's ability to gain and/or maintain access to HIV-related medical care or treatment.

Short-term or Emergency Housing Assistance Request Documentation of Need

Date: _____

Client Name: _____

Case Manager: _____

CARE Act Funds Utilized for Client's Housing-related Assistance: **Title I __ / Title II __ / Title IV __**

I certify that the housing services for this client will provide the following direct medical or support services: including, but not limited to, residential substance abuse or mental health services, residential foster care, and assisted living services:

comments:

Or

I certify that housing assistance is essential to this client's ability to gain and/or maintain access to HIV-related medical care and treatment.

As short-term or emergency assistance is transitional in nature and is for the purpose of moving or maintaining an individual or family in a long-term, stable living situation, the following steps have been taken to identify, relocate, and/or ensure that the individual or family is moved to, or capable of maintaining a long-term, stable living situation.

comments:

_____

Signature *(by a qualified professional who makes decisions or coordinates health care for HIV positive individuals)*

This document should be included in the client file along with any client application for housing assistance.

Long-term Housing Strategies for Clients

Most case managers and housing services providers conduct intake interviews and needs assessments at the time of program entry for persons receiving housing services. Many also develop in-depth individualized service plans with a client to outline the goals and objectives for that client's participation in the program. This is particularly true in emergency and transitional housing programs, which are intended to address a range of client issues in addition to the housing need.

Under the HAB housing policy, providers must ensure that proper documentation of the need for housing is obtained from qualified professionals, and that the certification is kept with the client's file, as described above. The case manager or housing provider also must develop a housing strategy to identify long-term housing options for the client that will be paid for by sources other than CARE Act funds. This may be a separate plan, or a part of a broader individualized service plan.

The emphasis of the housing strategy is on identifying and obtaining other funding resources to assist the client long-term, if necessary. The strategy is not intended to require that the client move to a new location. Some clients currently live in housing for which another subsidy may be found, minimizing displacement. In other cases, continued assistance may require a move to an assisted facility. In many cases, the objective of the housing strategy will be to transition the client off housing assistance altogether.

Good housing strategies assess the client's ability to live independently, to pay rent, and to live with or without specific types of supportive services. Assessments should take into consideration a client's:

- current and potential income;
- credit and rental histories;
- health;
- mobility;
- household size;
- familial or community support; and
- any other factors which may qualify or disqualify him/her from certain types of housing assistance in the community.

Housing strategies will also need to consider the availability of long-term housing subsidies in determining realistic time frames and options. In a community with a ten-year wait for Section 8 housing, waiting for a certificate to become available is not a realistic transition plan. Case managers and housing providers will have to work with clients specifically around planning to live without a subsidy if no other resources can be expected to become available within a reasonable period of time.

In developing the long-term housing strategy, a provider must identify sources other than the CARE Act to fund the long-term assistance required by the client. To do this, providers should make use of the information identified in the coordinated planning process described below to identify the most appropriate and likely alternative sources, if any, for each client.

As with the certification of need for housing services, long-term housing strategies will need to be updated and revised periodically, in keeping with the client's progress. Reassessment of the client's status and modification of the long-term housing strategy to respond to the client's current situation should occur as appropriate on an ongoing basis, but in all cases at least every six months.

While housing providers or case managers will have to prepare the long-term housing strategies individually with each client, the grantee is responsible for ensuring that these plans are being developed and carried out in a way that meets the requirements of the HAB housing policy. Depending on the community, the grantee may wish to develop a single standardized housing plan format to be used by all providers in the CARE network, or may prefer to allow different formats, provided that the critical components are present.

Strategy A: Develop a standardized long-term housing strategy format for use throughout the EMA

Example:

Community A has a small number of housing service providers and case management agencies and already coordinates intake procedures. A committee of grantee staff, planning council members, case managers/care coordinators, and housing providers review the HAB housing policy guidance together and design a set of forms to document both clients' housing needs and the long-term housing strategy. The committee circulates the forms to the broader community for comment, then brings the forms to the council or consortium for endorsement and to the grantee for adoption and dissemination. All AIDS housing and services providers in the community utilize the same format. Advantages of this strategy include assurance that the strategies meet HAB requirements and the ability for agencies to share client strategies if working with the same clients, or if a client moves to another agency for a similar service.

Strategy B: Adapt existing service plans to meet the HAB housing policy requirements

Example:

In Community B, most emergency and short-term housing providers have already developed agency-specific intake forms and individualized service plans to track the needs and goals of clients in a variety of areas, including health, psycho-social needs, income, and housing. Agencies do not want to change to a separate format for the housing documentation. The grantee provides each housing service provider with a list of required elements for the documentation, based on the HAB housing policy guidance. Providers review their current forms and make amendments, as necessary, to capture the appropriate information and document the housing strategy. The grantee reviews and approves the forms used in each agency, and trains monitoring staff to recognize the required language within other documents. Advantages of this approach include a reduction of the burden on providers to adopt new procedures and increased flexibility in developing strategies targeted to specific subpopulation groups.

Planning and coordination/ payer of last resort

The grantee for the area is required to demonstrate that CARE Act funds are utilized in coordination with other local, State, and Federal housing programs, and to document that the use of these funds is as payer of last resort. As part of the requirement that clients develop long-term housing strategies, HRSA wants communities to conduct an evaluation of all funding streams for housing to determine which other funding sources can provide assistance to CARE Act clients. The expectation is not that a new analysis be done every time an individual is assisted, but that planning is coordinated and other funding streams are identified prior to the allocation of CARE Act housing assistance funds.

Coordinated planning should include developing an inventory of housing resources available within the community that can be used to provide long-term assistance for persons receiving CARE Act-funded housing assistance. Examples of coordination include participation in the development of a specific AIDS housing plan for the area or a portion of it; participation in one or more Consolidated Planning processes within the area; participation in a homeless Continuum of Care planning process; coordination with local HOPWA advisory boards; coordination with local housing authorities; participation in State-sponsored housing planning; and participation in other community planning efforts on housing issues. (More detail on Federal housing planning processes is provided in "HUD Programs and Planning Processes," on page 42, and "HRSA/HAB CARE Act Programs and Planning Processes," on page 48.)

To document coordination, grantees and/or planning councils/consortia may wish to enter into memoranda of understanding with local agencies responsible for the planning processes described above. These might include local community development departments that administer HOPWA and other housing funds, HOPWA advisory boards and Continuum of Care boards, housing services collaboratives, or affordable housing advocacy networks engaged in local resource allocation and planning.

Grantees and planning councils/consortia should also present the information obtained from the coordinated planning efforts in the Title I or Title II annual application for funding, particularly in the funding request section regarding data/information used for priority setting and allocation of funds.

HAB Housing Policy – Impact Area Three:
Implementing Funding/Program Changes to Comply with HAB Housing Policy

Requirement	Impact	Strategy/Solution	Who is Involved?
CARE Act funds may only be used to support housing referral services and emergency or short-term housing assistance. (The housing assistance must be necessary to gain or maintain access to medical care. Emergency or short-term housing assistance must include development of a long-term housing strategy.)	Communities using CARE Act funds for permanent housing or for housing that is not linked to a medical need must make changes in the funding or operations of their continuum to comply with the HAB housing policy, while taking care not to displace PLWH who are currently receiving assistance.	**Strategy A: HOPWA/CARE Act shift:** HOPWA and CARE Act grantees in an EMA shift activities covered by these sources to ensure compliance with CARE Act restrictions; if change is not immediate, grantees and providers develop an implementation plan and time line and share them with a HRSA project officer.	CARE Act grantee, HRSA, HOPWA grantee, housing assistance provider(s), community advisory bodies.
		Strategy B: Identify replacement funds: Housing assistance providers seek and obtain other funds to cover costs previously funded by the CARE Act; if change is not immediate, grantees and providers develop an implementation plan and time line and share them with a HRSA project officer.	Housing assistance providers, grantees, HRSA, local, State, and Federal funders.
		Strategy C: Reconfigure programs: CARE Act-funded programs change nature of programs or CARE Act-funded portions of programs to provide short-term or emergency housing assistance; grantees and providers develop an implementation plan and time line and share them with a HRSA project officer.	Grantee, HRSA, housing assistance providers, planning council or consortium.

Implementing Funding/Program Changes to Comply with HAB Housing Policy

The steps outlined in the sections above will go a long way to address areas in which a grantee may be out of compliance with the HAB housing policy. In some communities, CARE Act funds have been spent on housing services which are not eligible. Disallowed costs include long-term housing subsidies, operational expenses of permanent housing programs, operating costs for independent living programs not linked to medical care and/or supportive services, and housing development expenses. In these communities, the effects of the HAB housing policy are potentially enormous, as alternative sources of funding must be found for hundreds of people living with HIV/AIDS currently housed through the use of CARE Act funds.

Grantees are responsible for ensuring that CARE Act funds are spent in accordance with the law and governing regulations, including the implementation of the HAB housing policy. They are also responsible for ensuring that the needs of people living with AIDS are met within their jurisdiction. This means that grantees in communities significantly impacted by the HAB housing policy must deliberately implement the policy while simultaneously working to minimize displacement of people living with HIV/AIDS.

In general, planning councils set priorities for the allocation of funds to categories for application to HRSA. Consortia set priorities and may be involved in decision-making about the allocation of funds. In communities where CARE Act funds have been used to support housing activities that are now not eligible for Ryan White funding, these groups will need to participate in the redirection of CARE Act funds and assist in developing alternatives.

Housing providers and residents will be the most impacted by the potential changes implied by the redirection of CARE Act funds. In some cases, the viability of programs or agencies may be threatened by a drastic shift in funds. Housing providers will need to be an integral part of any community response related to implementing the HAB housing policy. The grantee will need to work closely with its planning bodies and housing providers to identify alternative strategies and to define workable time lines. Transition plans should be initiated by FY 2000 and implemented during FY 2000. Although no formal approval is required, it is recommended that grantees consult with their project officers as they develop transition plans.

Three possible transition strategies and some examples are outlined on the following pages.

Strategy A: HOPWA/CARE Act Shift

Forty-four percent of housing providers that receive CARE Act funds also receive grants from the HUD Housing Opportunities for People with AIDS (HOPWA) program. The HOPWA program is a flexible block grant that can be used for a wide range of housing and housing-related services for people living with HIV/AIDS, including all services allowed under the CARE Act. The chart on page 22 contrasts eligible HOPWA housing services with those for which CARE Act funds may also be used.

In communities that receive both CARE Act and HOPWA funds, there may be some potential to trade or shift some of the activities covered by each source. This may be accomplished within a single program supported by both sources through a shift of line items within the program's budget. This may also be done among two or more programs within the AIDS housing continuum in a community, or by agreement between the funding sources relating to future funding cycles.

The following three examples illustrate ways to shift CARE Act and HOPWA funds to implement the HAB housing policy and continue the operation of existing programs.

Example 1-Single program shift

In Community A, CARE Act funds have been used to fund the operations of a permanent housing facility dedicated for persons with HIV/AIDS. Over the years as support service needs have increased, HOPWA funds were obtained to pay for additional supportive services for the tenants, including case management, substance abuse and mental health services. In this scenario, HOPWA and the CARE Act could shift the expenses each is covering in the facility, allowing HOPWA to pick up the operations of the building and the CARE Act to pay for supportive services. Note that in this case the CARE Act funds would have to come out of the local allocation for the appropriate supportive service (substance abuse treatment, mental health treatment, etc.), not from housing assistance.

Example 2-Cross program shift

In Community B, CARE Act funds have been used to fund an ongoing long-term rental assistance program. HOPWA funds in this community are being used to support dedicated AIDS beds in a local emergency shelter. These two programs are operated by different non-profit agencies. In order to comply with the HAB housing policy, the HOPWA and CARE Act grantees can arrange to shift the funds used for these contractors. (This may be especially practical if the HOPWA and the CARE Act grantees are the same agency.)

Example 3-Division of activities through a joint request for proposals (RFP)

In Community C, both Ryan White and HOPWA funds are made available through an annual Request for Proposals process. Previously, Ryan White and HOPWA funds were allocated separately and uses of the funds were sometimes overlapping. In order to meet the requirements of the HAB Housing Policy, the HOPWA and Ryan White grantees have agreed to issue a joint RFP for housing assistance. In reviewing applications, the grantees will assess the proposed activities for eligibility under each of the funding sources. Contracts will be developed based on the most appropriate blend of sources.

A CARE Act/HOPWA shift may present a challenge in communities where CARE Act and HOPWA programs have little or no connection, and no collaborative history. In many communities HOPWA and the CARE Act do not operate on the same annual cycle, or HOPWA funds are not reallocated annually. CARE Act grantees and housing providers may need to work together to influence HOPWA grantees, advisory boards, and local officials to modify the HOPWA funding process to ensure no gaps in housing services result from the changes in allocation of CARE Act funds.

As the shifting strategy may require HOPWA and CARE Act grantees to enter into contracts with agencies with which they have had no previous contractual experience, this strategy may be best to implement at the time of local contract renewals or reapplication processes. Housing provider agencies with shifting budgeted items will need to understand the regulations and requirements that come with the new funds. They may also need time to come into compliance, including addressing potential changes in the amount of funds that are available to cover administration. Where possible, existing contractual requirements should be preserved to avoid increased costs to the provider agency from the shift.

CARE Act and HOPWA Eligible Activities

The following chart details allowable activities, including housing-related expenses, under HAB Policy 99-02 of the Ryan White CARE Act and the HOPWA program.

← Allowable HOPWA Expenses →

← Allowable CARE Act Expenses →

Primary Medical Care, Emergency Assistance, Supportive Services, and Early Intervention Services	Housing Assistance*		Long-term Housing Assistance*	Housing Development (Capital)	Other Housing-Related Activities
	Housing Referral Services	Short-term or Emergency Housing Assistance**			
• Primary medical care (e.g. drug therapies, substance abuse treatment, payment for emergency residential treatment/ detoxification, mental health treatment, nursing and attendant care, hospice services) • Support services that enhance access to care (e.g., case management, meals/ nutritional support, transportation)*** • Other health and supportive services *** • Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing, and referral	• Assessment, search, placement, and advocacy services (provided by professionals who possess an extensive knowledge of local, State, and Federal housing programs and how they can be accessed)	• Emergency housing assistance (hotel vouchers, eviction prevention, short-term rental assistance) • Emergency shelter stays • Temporary/ transitional housing programs • Short-term residential treatment • Temporary assisted living	• Permanent housing • Independent • Supportive • Long-term tenant-based rental assistance • Project-based assistance • Long-term assisted living	• Acquisition • Rehabilitation • New construction • Master leasing	• Mortgage assistance • Technical assistance and resource identification (pre-development)

* Housing assistance includes programmatic and operating costs for each allowable type of housing. In most emergency or short-term housing programs, operating costs (including security, insurance, utilities, maintenance, etc.) are assumed under a daily bed-night or treatment night reimbursement rate.

** Use of CARE Act funds for short-term housing assistance must be linked to medical and/or supportive services. Short-term housing assistance must be certified as essential to a client's ability to gain and/or maintain access to HIV-related medical care or treatment.

*** The service category of "Emergency Assistance" (which falls under Supportive Services and Other Health and Supportive Services) cannot be used to fund housing referral and short-term or emergency housing services. Emergency housing needs must be funded under the category of "Short-term or Emergency Housing Assistance," described in this chart. However, other housing-related emergency expenses such as utilities can be included under the service category of "Emergency Assistance."

Strategy B: Replace CARE Act funds over time with funds from other sources

If a community receives no HOPWA dollars, or none of its HOPWA funds are being used to support activities which can be covered by CARE Act funds, then housing providers will need to look at other sources to replace CARE Act funds.

HUD's homeless programs, such as the Supportive Housing Program or Shelter Plus Care, may be appropriate resources with which to do this. These programs are designed to support housing programs and can provide support for housing operations or long-term rental assistance, as well as supportive services. Most HUD homeless funds target persons with disabilities, including HIV/AIDS. Actually obtaining these funds, however, will be difficult in some communities. In many areas Federal housing and homeless funds are oversubscribed, and jurisdictions are now dealing with a crisis of insufficient Federal funding to continue already funded homeless services. HUD homeless funds are also more restrictive than either HOPWA or CARE Act in terms of client eligibility and allowable uses of funds. In addition, HUD is prohibited from allowing Supportive Housing Program funds to replace the loss of funding from other Federal sources in an existing facility, except in cases where the funds are nonrenewable, the funds will cease before the end of the calendar year in which the application is made, the activity will cease to occur if not funded, and no other sources of funding are available. (For more information on HUD homeless programs, see "HUD Programs and Planning Processes," page 42, and *Financing AIDS Housing*, available from AIDS Housing of Washington.)

Locally controlled programs, including the Federally funded HOME program and Community Development Block Grants, may be more flexible for this purpose but may also be oversubscribed. Some communities may be able to allocate additional general funds to cover gaps or receive funds from the State to replace some of the CARE Act funds that need to be redirected. Communities that have utilized CARE Act funds for housing services that are no longer eligible will be able to reallocate these funds to other HIV services. Thus, a switch such as that envisioned using HOPWA funds might be possible with alternative sources currently funding other aspects of the HIV service network. Private funders may also be able to provide gap funding, although in many cases they may be unwilling to support the ongoing operations of housing programs or rental assistance.

Finally, housing providers that do not currently charge their residents rent may be able to recover a portion of their costs through tenant rents. If HUD funds are in the project, then providers will probably be limited to charging 30 percent of the tenants' income. Even without HUD restrictions, however, this recovery source is limited because the client population targeted is generally unable to pay very much for rent.

Strategy C: Reconfigure existing programs to be short term

If a community has no ability to switch funds or to replace CARE Act funds with other sources, it may consider reconfiguring its current programs to meet the HAB housing policy's requirements by providing housing assistance on an emergency or short-term basis.

Reconfiguring an existing program effectively may be challenging. It will require evaluating the impact of reconfiguration on the existing participants, and determining whether other funding sources will allow a change in the duration or nature of the program. It also must take into consideration whether other aspects of the program, such as staffing and the service package, will continue to be appropriate or must also be modified. In many cases, CARE Act funds make up only a portion of the overall program budget, and a partial reconfiguration of the program may be possible.

Example 1-Rental assistance

Community A has used CARE Act funds to fund rental assistance for people living with HIV/AIDS. Once clients begin to receive the subsidy, they are assisted until they move out of the area, die, or have a significant increase in income that makes them ineligible for further assistance. Under the HAB housing policy, Community A has decided to reorient the rental subsidy program to be short-term. The new program will have two components, a "move-in and transitional assistance" component for homeless persons finding housing, and a prevention component for persons with housing who are in imminent danger of losing their housing without immediate assistance. Since there are already persons in the program, Community A has decided to begin by assessing current clients and assisting them to develop long-term housing strategies. As clients leave the program, their slots will be converted to short-term assistance slots.

Example 2-Site-based

Provider B has been using CARE Act funds, along with other sources, to operate a medium size apartment building dedicated for people living with HIV/AIDS. The apartments have provided permanent, supportive housing with on-site services. CARE Act funds make up approximately 25 percent of the program's operating budget. As units turn over, Provider B has agreed to convert 25 percent of the building's units to short-term transitional housing units. To do this, Provider B will have to seek a grant amendment from HUD and the local community development agency that provided Federal homeless program funding to the project initially as a permanent housing project.

The time line to fully reconfigure an existing program will vary depending on the housing market in the community, the rate of turnover in the programs, and the ability to secure waivers or agreements from funding sources. In large programs this transition may take a number of years. Grantees should negotiate a time line for conversion with the affected housing provider, including benchmarks to measure progress. The grantee should also consult with its assigned HRSA project officer if the transition is expected to be delayed, and should share the transition plan with the project officer in writing.

Q & A on the Use of CARE Act Funds for Housing Referral Services and/or Short-term or Emergency Housing Assistance

1. Under what conditions can CARE Act funds be used for housing referral services and/or short-term or emergency housing assistance?

CARE Act funds can be used for housing referral and/or short-term or emergency housing assistance to assist a person or family with HIV/AIDS to gain and/or maintain access to HIV-related medical care or treatment.

2. What does "Housing Referral Services" mean?

"Housing Referral Services" are assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State, and Federal housing programs and how they can be accessed.

3. What does "Short-term or Emergency Housing Assistance" mean?

"Short-term or Emergency Housing Assistance" is financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of CARE Act funds for "Short-term or Emergency Housing Assistance" must be linked to medical and/or supportive services. These services can include, but are not limited to residential substance abuse or mental health services (not including facilities classified as Institutes of Mental Diseases under Medicaid), residential foster care, and assisted living residential services. "Short-term or Emergency Housing Assistance" must be certified as essential to a client's ability to gain and/or maintain access to HIV-related medical care or treatment.

4. How do grantees document that housing assistance is essential to the client's ability to gain and/or maintain access to HIV-related medical care or treatment?

Each grantee must have in place written procedures to ensure that the client's housing assistance is essential to the client's ability to gain and/or maintain access to HIV-related medical care or treatment. Documentation may be a letter or a standard form developed by the grantee. The documentation must certify that the housing assistance is essential to the client's ability to gain and/or maintain access to HIV-related medical care or treatment. Documentation must also provide evidence of compliance with other assurances related to eligibility and payer of last resort as described in HAB Policy Notice 99-02 and explained in sections of this document.

5. Where should this documentation be located?

Primary documentation should be located in the client's file on-site in at least one location among the CARE Act-funded network. This may include the client's case management file or the files established by a qualified professional who coordinates health care. Client files at every location should include primary documentation or reference to the primary documentation in the form of a certified referral form or a notation that eligibility for housing assistance has been confirmed.

6. Should this documentation be certified by a primary care physician?

The documentation does not have to be certified by a primary care physician. The

certification should be signed by a qualified professional who makes decisions or coordinates health care for HIV-positive individuals. Qualified professionals may include but are not limited to nurses, case managers, physicians, or care coordinators.

7. What happens if the housing needs of the individual and/or family are long-term?

CARE Act funds should be used to assist an individual and/or family transition into a long-term, stable living situation. The implementation of this policy is intended to limit the use of CARE Act funds for housing assistance. CARE Act-funded housing assistance cannot be permanent and must be accompanied by a plan to identify other sources of funding to pay for the long-term housing needs. The emphasis should not be on moving a client to a new location, but on identifying and obtaining other funding resources to assist the client.

8. How often are grantees required to reassess the housing situation of clients assisted with CARE Act funds?

CARE Act-funded housing assistance cannot be permanent and must be accompanied by a plan to identify other sources of funding to pay for long-term housing needs. These housing plans should be reassessed at least every six months. Again, the emphasis should be on identifying and obtaining other funding resources to assist the client.

9. Can security deposits be made using CARE Act funds for housing?

Payment of security deposits is allowable as long as grantees develop a system for retrieval of deposits and apply the returned amounts toward new requests. Such a mechanism may include a revolving fund or another system but must not allow for a direct cash benefit to the client.

10. Can mortgage payments be made using CARE Act funds for housing?

Mortgage payments are not allowable expenses under this policy or under any CARE Act-funded activities.

11. How do we ensure that a short-term housing solution using CARE Act funds does not become permanent?

Grantees and providers are responsible for developing plans in coordination with other programs to identify funds and resources to ensure that individuals and/or families will be able to maintain a long-term, stable living situation. An evaluation of all funding streams for housing should be done in order to develop transition plans. Technical assistance will be made available to grantees that need help in this area. Please contact your project officer for more details.

12. Are grantees required to develop time limits for short-term and/or emergency assistance?

While HRSA doesn't require specific time limits for short-term and/or emergency assistance, we require that grantees document plans to transition funding for individuals and/or families to support long-term living situations. These plans should reflect the limited short-term and emergency usage of CARE Act funds for housing as appropriate.

13. Can CARE Act funds be used in place of funds currently being used from local, State, and Federal agency programs?

The CARE Act must be the payer of last resort. Funds used for housing services must be used to supplement but not supplant funds currently used from local, State, and Federal agency programs. Grantees must be capable of providing the HIV/AIDS Bureau with documentation related to the use of funds as payer of last resort and the coordination of such funds with other local, State, and Federal funds.

14. Can funds from all of the CARE Act titles be used for housing and housing-related expenditures?

CARE Act housing-related expenses are limited to Titles I, II, and IV. Housing-related expenses are not an allowable expense under Title III.

15. How does this policy affect funds that may be allocated toward housing under another service category such as "Emergency Assistance?"

HAB Policy Notice 99-02 supercedes *Program Policy Notice 97-02.6, "Emergency Assistance for Eligible Individuals."* The service category of "Emergency Assistance" cannot be used to fund housing referral and short-term or emergency housing services. Other housing-related emergency expenses such as utilities can be included under the service category of "Emergency Assistance." Emergency housing needs must be funded under the category of "Housing Assistance."

16. How will this policy affect service categories and priority setting?

This policy should be used to help planning councils and grantees differentiate between the various types of eligible housing activities that can be funded. "Housing Referral Services" and "Housing Assistance" are two separate categories. "Housing Assistance" should be divided between short-term and emergency.

17. What will be required of grantees that use funds under this policy?

Grantees who use CARE Act funds for housing will be required to document that: 1) CARE Act is the payer of last resort; 2) CARE Act funds are utilized in coordination with other local, State, and Federal housing programs; and 3) a plan is in place to ensure a long-term permanent and stable living situation for the individual and/or family. Finally, in cases where the provision of housing services does not provide direct medical or supportive services, documentation of the necessity of housing services to enable the client to gain and/or maintain medical care must be recorded in the client's file.

18. When is this new policy effective?

HAB Policy Notice 99-02 was signed by the HAB Bureau Director and sent to all Ryan White CARE Act grantees on May 11, 1999. It became effective on that date.

19. What role will HRSA play in assisting grantees in the implementation of this policy?

HRSA's HIV/AIDS Bureau understands that due to contracting cycles and the need to develop and implement plans to carry out this policy, grantees may have to phase in these requirements. Grantees should discuss the implementation of the policy with their project officers. HAB is working with several Federal and national organizations to identify technical assistance that will be made available to grantees.

The Current State of HIV/AIDS Housing in the United States

Today, there is more uncertainty in the AIDS housing community than ever before. There are multiple factors that impact the planning for, and provision of, AIDS housing and supportive services. They include: limited Federal funding, the pervasive lack of affordable housing, the expanding number of people living with HIV/AIDS with complex histories of homelessness, mental illness and substance abuse, and advances in AIDS treatment protocols.

Below is an overview of the state of AIDS housing in the United States in 2000.

A Brief History of AIDS Housing

AIDS housing has developed over the past 15 years in response to the needs of low income and special needs populations for housing that includes an array of supportive services. Without on-site services, these populations would not be able to maintain housing stability or find and retain employment. In the case of housing for persons living with HIV/AIDS, the fluctuating nature of the disease suggests that some level of supportive services, these include case management, at a minimum, as well as access to community-based medical services, is a necessary component of all types and models of residential programs.

The history of AIDS housing dates back only to the mid-1980s. The first projects were started by visionary individuals–many had lost a partner or family member to HIV/AIDS–who responded to an unmet need. The earliest projects were in "first-wave" communities: New York, San Francisco, and Los Angeles. At that time no specific funding dedicated for AIDS housing existed, and the projects were developed with local corporate and foundation monies, the generosity of individuals, some local government funds, and hours of volunteer labor. Many of these initial projects were small: four- to eight-bed group homes providing independent housing, or small facilities providing hospice care. All relied on volunteers to supplement the work of few, if any, paid staff.

Most of the initial AIDS housing projects did not have a continuum of community-based AIDS support services on which to rely to supplement volunteer staffing, so they developed creative mechanisms whereby intermittent home health care services were paid for by Medicaid or reimbursed through funding from local government jurisdictions. These housing projects often provided care to their residents through the end of their lives and focused more on the psychosocial needs of residents and their families and friends than on sophisticated medical interventions. Few were licensed, and none had dedicated reimbursement streams, such as those used in residential projects serving mentally ill or developmentally disabled populations.

AIDS housing is very different in 2000. Any project that began in the mid-1980s and is still open today has most likely undergone major physical remodeling and, in many communities, now meets local licensure requirements. Virtually every project that exists today has paid staff, receives government funding, has written operating policies, and would describe itself as targeting one or more specific needs in the overall housing continuum.

Whereas the first providers of AIDS housing were nonprofits newly founded to care for people living with AIDS, in the 1990s much of

the development and provision of AIDS housing shifted to mainstream affordable and supportive housing providers, as well as public housing authorities and local governments. The first phase of the national AIDS housing cost study, completed in 1999 by Vanderbilt University, found that nearly 28,000 units of housing in the U.S. are dedicated for people living with HIV/AIDS. Most of these units (17,190) are rental assistance slots, integrating people living with HIV/AIDS into the mainstream community.[3]

Who is providing AIDS housing?

The national AIDS housing cost study found that the majority of AIDS housing providers (87 percent) are nonprofit organizations, both faith- and non-faith-based. Ninety percent have been in operation more than five years and over half were founded before 1990. The median age of the organizations is 12 years; however, their involvement in operating AIDS housing or providing rental assistance is, on average, five to six years. Only 25 percent of the organizations have been operating buildings with HIV/AIDS dedicated units for a decade or more.[4]

Where is AIDS housing available?

The national AIDS housing cost study determined that every State has at least one AIDS housing provider. As expected, the largest numbers of providers are in populous States with large urban centers; over one quarter of the providers are located in California and New York alone.

Housing for persons living with HIV/AIDS is not limited, however, to urban areas. Fifty-three percent of the organizations surveyed provide some housing assistance to rural or nonmetropolitan populations (populations of less than 50,000). However, nearly half of the organizations that provide housing to rural or nonmetropolitan populations provide it only as a subset (25 percent or less) of their total housing assistance. One quarter of the organizations provide housing assistance to rural or nonmetropolitan populations only.[5]

Funding

A Vanderbilt University study determined that 66 percent of the nation's AIDS housing providers receive HOPWA funding for AIDS housing services, while 55 percent receive CARE Act funds. These two funding sources are extremely important to the ability of these agencies to provide AIDS housing and are also often used in tandem–44 percent of AIDS housing providers indicated that they receive funding from both HOPWA and CARE Act.[6]

While the number of people living with HIV/AIDS is increasing, there is less money to go around, and communities are grappling with the challenge of fairly and equitably prioritizing the services to be offered and the people to be served. Federal funding for HOPWA and other housing programs remains under extreme budgetary pressure.

[3] Rog and Goldwater, 1999.

[4] Ibid. (1999).

[5] Ibid.

[6] Ibid.

- **Sixty-six percent of the nation's AIDS housing providers receive HOPWA funding for AIDS housing services.**
- **Fifty-five percent of the nation's AIDS housing providers receive CARE Act funding for AIDS housing services.**
- **Forty-four percent of the nation's AIDS housing providers receive CARE Act and HOPWA funding for AIDS housing services.**[7]

Since 1992, when HOPWA was first authorized, the Federal government has made available more than $1.27 billion in HOPWA funds to support community efforts to create and operate HIV/AIDS housing initiatives. In 1992, there were 27 eligible metropolitan statistical areas (EMSAs) and 11 States eligible to receive formula allocations of $42.9 million in HOPWA funds. By 1995, funding had increased to $153.9 million, but the number of grantees had increased to 66 (43 EMSAs and 23 States). From 1995 to 1999, the number of grantees had increased by 49 percent to 97 eligible States or metropolitan areas, while funding had only increased by 30 percent to $200 million.

Although the HOPWA allocation increased by approximately $20 million in FY 2000, additional jurisdictions are eligible to receive funding. Meanwhile, the number of people living with AIDS is increasing. More individuals are eligible for and in need of services, and communities are faced with the challenge of utilizing limited resources to meet multiple needs.

Since 1991, the first year the CARE Act was funded, more than $5.5 billion has been appropriated to Titles I and II, the two titles that allow housing related expenditures. In 1999, Title I grantees [eligible metropolitan areas (EMAs)] were awarded $485.8 million in formula and supplemental funds.

Title II grantees (States) received a total of $710 million in 1999, including $461 million earmarked for pharmaceuticals under the AIDS Drug Assistance Program (ADAP).

Nearly 40 percent of Title I and Title II grantees fund housing services. In FY 1999, an estimated $40 million was proposed for housing services by CARE Act grantees.[8]

Affordable Housing

In addition to the funding concerns summarized above, there is an affordable housing crisis in the United States.

Throughout the country, low income individuals struggle to find safe, affordable housing. Concurrently, the strong economy in many jurisdictions is having a negative effect on low income individuals whose incomes have not kept pace with rent increases.

Beginning in 1996 there have been decreases in the number of households able to access public and assisted housing. In 1997 and 1998, HUD programs served 31,000 and 20,000 fewer households, respectively.[9] In many communities, if low income individuals currently housed in public and assisted housing were not receiving assistance through public or Section 8 housing, they would face significant challenges to finding affordable housing. Overall, if these individuals were renting on the open market, they would need to spend 74 percent of their income, on average, for a housing unit to pay the fair market rent (FMR) established by HUD.

[7] Ibid.

[8] Information presented at September 1999 HOPWA Grantees Meeting in Baltimore, MD, by HRSA staff.

[9] National Low Income Housing Coalition, "Out of Reach," September 1999. Available at www.nlihc.org.

- **Nowhere in the United States is the minimum wage adequate to afford the two-bedroom fair market rent (FMR).**
- **In more than three quarters (76 percent) of U.S. counties, households earning 50 percent of median income could not afford the FMR for a two-bedroom unit.[10]**
- **Forty-one percent of AIDS housing consumer survey respondents indicated they had been homeless at some point in their lives, and 7 percent of respondents were currently homeless.**
- **Thirty-eight percent of AIDS housing consumer survey respondents were disabled by mental illness, while 27 percent were in drug or alcohol treatment.[11]**

The table below demonstrates the affordability gap for low income renters in select U.S. cities by comparing the fair market rent (FMR) for the cheapest apartments (studio or zero-bedroom unit) in the metropolitan statistical area (MSA) with how much extremely low income renters (those who earn 0-30 percent of median family income) can afford to pay without incurring a housing cost burden. This burden is the extent to which gross housing costs, including utility costs, exceed 30% of gross income. Note that FMRs are reported at the MSA level only, without regard to regional market variations or market variations within a single jurisdiction. For these reasons, the actual affordability gap presented below is likely to be understated.

One inevitable result of the housing affordability crisis in the United States has been a burgeoning homeless population. While the number of homeless in any community is difficult to estimate, one study found that in 1996 more than 700,000 men, women, and children were homeless on any given night, and up to 2 million were homeless at some point each year.[12]

People who are homeless often have multiple health issues, including mental health problems, substance abuse problems, and/or HIV infection. It is estimated that 25 percent of single homeless adults suffer from mental illness, while 30 to 35 percent of all homeless adults are abusing drugs or are addicted to alcohol.[13]

Other studies indicate that the prevalence of HIV among homeless people may be as high as 20 percent in some cities, although a recent report by the Federal Interagency Council on the Homeless found that just 3 percent were HIV-infected.[14]

[10] Ibid.

[11] AIDS Housing of Washington, *Consumer Surveys*, 1993-1999.

[12] National Coalition for the Homeless, Fact Sheet #2, 1997.

[13] Kilborn, Peter T., "Gimme Shelter: Same Song, Different Tune." *New York Times*, December 5, 1999.

[14] Federal Interagency Council on the Homeless, *Homelessness: Programs and the People They Serve, Findings of the National Survey of Homeless Assistance Providers and Clients*, December, 1999.

Housing Affordability Gaps for Low Income Residents (Selected Urban Areas), 1999

City/County	Monthly Income for Single Person at 0 to 30 % of MFI	Cost Burden Level (30% of Income)	FMR for Zero-Bedroom Unit	Monthly Housing Affordability Gap
Baltimore	$0-1,054	$0-316	$421	$105-421
Cleveland	$0-921	$0-276	$382	$106-382
Dallas	$0-1,016	$0-305	$487	$182-487
Miami	$0-779	$0-234	$449	$215-449
New Orleans	$0-708	$0-212	$364	$152-364
Orange County, CA	$0-1,196	$0-359	$645	$286-645
San Francisco	$0-1,267	$0-380	$713	$333-713

Sources: www.huduser.org/
Note: MFI is median family income.

Emerging Needs

HIV/AIDS cases are increasing among people of color, particularly youth, gay/bisexual men, and women.

- **It is estimated that at least half of all new HIV infections in the U.S. are among people under 25, and the majority of HIV-infections among young people are transmitted sexually.[15]**

In addition, as an increasing proportion of the people accessing HIV/AIDS services and housing have histories of homelessness, mental illness, and chemical dependency, planners and providers face challenging philosophical and practical issues. Demands on all of the systems serving people living with HIV/AIDS are increasing, but the resources necessary to meet identified needs may not be available in the future.

- **African Americans represent only 13 percent of the U.S. population, but accounted for 49 percent of AIDS deaths in 1998.[16]**

[15] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS Prevention, "Young People at Risk: HIV/AIDS Among America's Youth," Fact Sheet (August 1999), Available online at http://www.cdc.gov/hiv/pubs/facts/youth.htm, December 1999.

[16] CDC, National Center for HIV, STD, and TB Prevention, "New data show continued decline in AIDS deaths." (30 August 1999).

The provision of appropriate services for these populations is critical. Housing stability is often necessary for a person living with HIV/AIDS to gain or maintain access to medical care. However, it is very expensive to provide the level of support many of these individuals need in order to maintain their housing and be able to access necessary medical care and treatment.

Individuals who have had histories of chemical addiction, mental illness, and homelessness will need assistance to develop job skills, as well as ongoing support services, to be able to successfully maintain stable housing.

In just over a decade, the proportion of new AIDS cases reported among adult and adolescent women more than tripled, from 7 percent of cases reported in 1985 to 23 percent of cases reported in 1998.[17]

- **HIV/AIDS remains among the leading causes of death for women aged 25 to 44 in the U.S.[18]**
- **Almost two-thirds (62 percent) of all AIDS diagnoses in women in 1998 were among African Americans.[19]**

Medical Advances

People living with HIV/AIDS who are successfully being treated with Highly Active Anti-Retroviral Therapy (HAART) are experiencing significant improvements in health. Many people living with HIV/AIDS are considering re-employment and evaluating the impact that returning to work could have on their disability and medical benefits. Nationally, AIDS death rates decreased for the first time in 1996.

At the same time, however, not all individuals are able to access promising HIV treatments. The medications and monitoring associated with HAART are well over $10,000, putting them well out of reach of individuals who do not have adequate insurance or access to Sttate-run AIDS Drug Assistance Programs. Data show that people of color and women are often less likely to be prescribed these expensive drugs.

According to a review of case files in a large AIDS service agency, African Americans, individuals with annual incomes under $9,600, non-English speakers, and those who were not college educated were least likely to receive "optimal" treatment with the new therapies.[20] Homeless individuals are less likely to be prescribed protease inhibitors because they are often viewed as unable to follow complicated medication protocols.

[17] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS Prevention, "HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk," Fact Sheet (August 1999), available online at http://www.cdc.gov/hiv/pubs/facts/women.htm, December 1999.

[18] Ibid.

[19] Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS Prevention, "HIV/AIDS Among African Americans." Fact Sheet (August 1999), available onlineat http://www.cdc.gov/hiv/pubs/facts/afam.htm, December 1999.

[20] Kaiser Family Foundation Daily HIV/AIDS Report, May 10, 1999. Available online: http://kff.org/search/hivaids.html.

Sustaining AIDS Housing

There are now nearly 1,000 providers of AIDS housing, and, as the AIDS housing community arrives at the twenty-first century mark, our priorities and responsibilities are shifting. The epidemic has changed, the housing and residential care needs of people with AIDS have changed, the populations affected and infected have changed, and many providers are changing as a result.

The focus of AIDS housing providers has shifted from assisting people at the end of their lives to assisting them with the transition to living with HIV and AIDS. Some people living with HIV/AIDS have returned to work, or are thinking about the possibility of going to work. At the same time, they are concerned about losing their benefits associated with disability if they become sick again. They need to be sure that they have health insurance coverage for medications, and access to disability benefits and services should the need arise.

AIDS housing providers are seeing more and more clients with histories of homelessness, mental illness, and/or substance abuse, with HIV often secondary or tertiary among a client's concerns. Multiple diagnoses make the measurement of success for tenants more complex; positive outcomes range from housing stability, improved health status, and sobriety to decreasing use of nonprescription drugs and gaining life skills that may lead to employment.

Much of AIDS housing began as a vision that included an elaborate web of paid and volunteer services that focused on compassionate care. Now housing is often a contractual relationship based on the payment of rent and meeting lease requirements, not on participation in a program. Therefore, providers have had to learn to operate permanent housing within the context of landlord-tenant laws.

Providers outside of metropolitan areas, especially in the scattered towns of rural America, have their own challenges, including transportation to care, minimal community knowledge of the disease, and a lack of rental housing units. Rural AIDS housing providers are also often burdened with a lack of experience, few partnering or collaborative opportunities, and a dearth of funding opportunities. They have had to learn to innovate and stretch their dollars any way they can (often with short-term rental assistance programs) to serve their growing client base.

New words now sprinkle the housing vocabulary: asset management, multiyear pro formas, reserve accounts. AIDS housing providers have a responsibility to their tenants to provide permanent housing to assure not only that the building is maintained but that ongoing operating subsidies and support services are in place.

While the AIDS housing community's goal of meeting the housing needs of people living with HIV and AIDS has not changed, the AIDS service and housing world has changed dramatically. The challenge for AIDS housing providers is to ensure that resources will be available to clients over the long term, and to find the balance between flexibility and stability.

HOPWA and CARE Act (Titles I and II) Funding

HOPWA and/or CARE Act Formula Jurisdictions	HOPWA FY 2000 Allocation ($ in thousands)	CARE Act Title I FY 2000 Total Grant Award ($ in thousands)	CARE Act Title II FY 2000 Base Grant Award (without ADAP) ($ in thousands)
Alabama	843	–	3,585
Birmingham	384	–	–
Alaska	–	–	281
Arizona	391	–	2,639
Phoenix/Mesa	1,010	5,002	–
Arkansas	574	–	1,626
California	2,489	–	32,538
Los Angeles/Long Beach	8,905	34,683	–
Oakland	1,702	6,705	–
Riverside/San Bernadino	1,435	6,914	–
Sacramento	665	2,744	–
San Diego	2,214	9,072	–
San Francisco	8,721	35,246	–
San Jose	660	2,612	–
Santa Ana/Orange County	1,170	4,671	–
Santa Rosa	–	1,152	–
Colorado	–	–	2,127
Denver	1,179	4,582	–
Connecticut	947	–	3,779
Hartford	847	4,418	–
New Haven	585	6,262	–

HOPWA and/or CARE Act Formula Jurisdictions	HOPWA FY 2000 Allocation ($ in thousands)	CARE Act Title I FY 2000 Total Grant Award ($ in thousands)	CARE Act Title II FY 2000 Base Grant Award (without ADAP) ($ in thousands)
Delaware	119	–	1,501
Wilimington	428	–	–
District of Columbia	6,335	19,904	3,508
Florida	3,331	–	27,331
Fort Lauderdale	5,125	11,438	–
Jacksonville	1,121	4,176	–
Miami	10,139	23,450	–
Orlando	1,888	6,008	–
Tampa	1,816	8,016	–
West Palm Beach	2,677	7,169	–
Georgia	1,333	–	8,398
Atlanta	3,610	15,508	–
Guam	–	–	17
Hawaii	138	–	1,183
Honolulu	375	–	–
Idaho	–	–	278
Illinois	558	–	7,349
Chicago	4,323	19,004	–
Indiana	654	–	3,406
Indianapolis	596	–	–
Iowa	–	–	696

HOPWA and/or CARE Act Formula Jurisdictions	HOPWA FY 2000 Allocation ($ in thousands)	CARE Act Title I FY 2000 Total Grant Award ($ in thousands)	CARE Act Title II FY 2000 Base Grant Award (without ADAP) ($ in thousands)
Kansas	–	–	1,049
Kentucky	602	–	2,040
Louisiana	763	–	5,384
Baton Rouge	630	–	–
New Orleans	1,888	5,936	–
Maine	–	–	459
Maryland	–	–	7,081
Baltimore	5,632	15,351	–
Massachusetts	1,173	–	4,797
Boston	1,980	12,469	–
Michigan	705	–	4,063
Detroit	1,577	7,235	–
Minnesota	92	–	1,057
Minneapolis/St. Paul	687	2,827	–
Mississippi	831	–	2,589
Missouri	405	–	2,899
Kansas City	816	3,064	–
St. Louis	962	4,239	–
Montana	–	–	250
Nebraska	–	–	594
Nevada	191	–	1,598
Las Vegas	731	3,689	–

HOPWA and/or CARE Act Formula Jurisdictions	HOPWA FY 2000 Allocation ($ in thousands)	CARE Act Title I FY 2000 Total Grant Award ($ in thousands)	CARE Act Title II FY 2000 Base Grant Award (without ADAP) ($ in thousands)
New Hampshire	–	–	317
New Jersey	1,497	–	12,815
Bergen-Passaic	–	4,627	–
Dover Township	605	–	–
Jersey City	2,272	5,542	–
Middlesex-Somerset-Hunterdon	–	2,751	–
Newark	5,791	14,554	–
Paterson	1,148	–	–
Vineland-Millville-Bridgeton	–	685	–
Woodbridge	677	–	–
New Mexico	415	–	1,170
New York	1,896	–	42,637
Albany	358	–	–
Buffalo	364	–	–
Dutchess County	–	1,209	–
Islip	1,399	–	–
Nassau-Suffolk	–	6,119	–
New York City	47,986	107,560	–
Rochester	491	–	–
North Carolina	1,276	–	5,811
Charlotte	428	–	–
Raleigh	400	–	–

HOPWA and/or CARE Act Formula Jurisdictions	HOPWA FY 2000 Allocation ($ in thousands)	CARE Act Title I FY 2000 Total Grant Award ($ in thousands)	CARE Act Title II FY 2000 Base Grant Award (without ADAP) ($ in thousands)
North Dakota	–	–	100
Ohio	852	–	5,120
Cincinnati	405	–	–
Cleveland	694	3,108	–
Columbus	465	–	–
Oklahoma	404	–	1,868
Oklahoma City	350	–	–
Oregon	–	–	1,603
Portland	809	3,216	–
Pennsylvania	1,198	–	9,309
Philadelphia	3,733	18,134	–
Pittsburgh	497	–	–
Puerto Rico	1,910	–	8,249
Caguas	–	1,714	–
Ponce	–	2,461	–
San Juan	6,080	13,558	–
Rhode Island	–	–	1,122
Providence	440	–	–
South Carolina	1,402	–	5,776
Columbia	903	–	–
South Dakota	–	–	102

HOPWA and/or CARE Act Formula Jurisdictions	HOPWA FY 2000 Allocation ($ in thousands)	CARE Act Title I FY 2000 Total Grant Award ($ in thousands)	CARE Act Title II FY 2000 Base Grant Award (without ADAP) ($ in thousands)
Tennessee	556	–	4,999
Memphis	1,031	–	–
Nashville	509	–	–
Texas	2,245	–	18,736
Austin/San Marcos	787	3,576	–
Dallas	2,562	11,077	–
Fort Worth/Arlington	674	2,969	–
Houston	7,114	17,665	–
San Antonio	823	3,163	–
Utah	387	–	1,058
Vermont	–	–	250
Virgin Islands	–	–	291
Virginia	494	–	5,278
Norfolk	–	4,090	–
Richmond	568	–	–
Virginia Beach	744	–	–
Washington	501	–	3,037
Seattle	1,405	5,489	–
West Virginia	–	–	617
Wisconsin	332	–	1,848
Milwaukee	405	–	–
Wyoming	–	–	100

HUD Programs and Planning Processes

Integration of CARE Act Allocation Process with HUD Housing Planning Processes

The primary Federal funder of housing development and operations is the U.S. Department of Housing and Urban Development (HUD). Its HOPWA program (Housing Opportunities for Persons With AIDS) is dedicated specifically to the variety of housing needs of people living with HIV or AIDS. Other HUD programs focus on the housing needs of a variety of low income communities, such as homeless individuals and families, disabled people, low income families, and seniors, but virtually all HUD programs can be used to house eligible people living with AIDS.

Two community-based planning processes are central to the allocation of most of the locally controlled housing dollars: the Consolidated Plan, and the Continuum of Care. The housing needs of people living with HIV and AIDS are among those that communities are specifically required by HUD to consider in the development of their Consolidated Plans and Continuum of Care processes. AIDS housing providers, planning councils and consortia, CARE Act grantees and people living with AIDS can, and should, all be involved in these efforts. Information gathered from CARE Act needs assessments and applications should also be shared with the planning groups or agencies organized to develop the Consolidated Plan and Continuum of Care processes.

One obstacle to the integration of CARE Act planning and HUD-required local planning is that the jurisdictions rarely converge. While CARE Act funds are planned for at a State or EMA level, except in rural communities, HUD Consolidated Planning usually occurs at a city level or a multi-city level, depending on the size of the region. Thus, a single EMA may be home to many Consolidated Plans.

The Continuum of Care process may occur at the same jurisdictional level as a Consolidated Plan, particularly in large metropolitan cities, or it may encompass two or more Consolidated Plan areas. Because the issue of homelessness generally crosses city boundaries, and homeless programs may serve several jurisdictions, smaller communities often find it beneficial to plan together over a larger region.

This section summarizes the Consolidated Plan and Continuum of Care planning processes and the programs that receive funds allocated through them.

The Consolidated Planning Process and Its Programs

HOPWA formula grants are allocated as part of the area's Consolidated Plan, which also includes the Community Development Block Grants (CDBG), the HOME partnership program, and Emergency Shelter Grants. Consolidated Plans are developed through a public process that assesses area needs, creates a five-year strategy, and proposes an annual action plan for use of Federal funds and other community resources in a coordinated and comprehensive manner. Each year, a new annual action plan is developed.

Local governments devise the Consolidated Plans and annual action plans in consultation with public and private agencies that provide supportive housing and social and health services, community members, and

neighboring localities. The action plan must indicate the activities that will be carried out in the upcoming year to address emergency shelter and transitional housing needs, homelessness prevention, the transition to permanent housing and independent living, and services for people who are not homeless but have supportive housing needs. The Consolidated Plan must also describe various regional characteristics, including the area's housing and homeless needs, characteristics of the local housing market, and public policies that impose barriers to the availability of affordable housing.

It is a requirement of HUD that a States or locality's Consolidated Plan must include significant citizen participation and public involvement. Therefore, each community has considerable decision-making authority over how funds will be used to meet targeted needs, including housing for persons living with HIV/AIDS and services to people who are homeless.

Housing Opportunities for Persons with AIDS (HOPWA)

The HOPWA program provides grant funds to State and local governments to design long-term, comprehensive strategies for meeting the housing needs of low income people living with HIV/AIDS and their families. The program provides participating jurisdictions with the flexibility to create a range of housing programs for eligible people and the capacity to individualize services to meet local needs.

Funds are available either through formula grants or competitive grants. Ninety percent of HOPWA funds are awarded through formula grants. HOPWA grantees may carry out eligible program activities themselves, deliver them through any of their administrative agencies, or select or competitively solicit project sponsors. Grantees and project sponsors may also contract with service providers, including for-profit entities, pursuant to U.S. Office of Management and Budget (OMB) procurement requirements, to provide services associated with their HOPWA activities.

The remaining ten percent of HOPWA funding is awarded through competitive grants under the following categories of assistance:

- Grants for *Special Projects of National Significance* (SPNS), which because of their innovative nature or their potential for replication are likely to serve as effective models in addressing the needs of eligible persons. Any State, locality, or nonprofit organization may apply for a SPNS grant.
- Grants for Projects that are part of *Long-Term Comprehensive Strategies* for providing housing and related services for eligible persons. Applications for this category can be submitted by States and local governments that are not eligible for HOPWA formula allocations during the applicable fiscal year.

Community Development Block Grants (CDBG)

The Community Development Block Grants (CDBG) program provides funds to nearly every community in the country–including metropolitan cities, urban counties, small cities, small counties, Indian tribes, and Alaskan native villages–to support the development of viable communities. Funds may be used in various ways to support community development, including acquisition, construction, and rehabilitation of public facilities and housing. While CDBG funds may be used for a wide variety of activities, including housing-related services, communities are not required to include housing when determining how they would like to use CDBG funds.

All CDBG projects must address one of the three national objectives of the program:

1. benefit low and moderate income people;
2. eliminate or prevent slums or blight; and
3. when no other financial resources are available, meet other community development needs that are particularly urgent because existing conditions pose a serious and immediate threat to the health and welfare of the community.

The majority of CDBG funds are allocated through two programs–the entitlement communities program and the States/Small Cities program. The entitlement communities program grants money to metropolitan cities and urban counties to support the development of urban communities. The States/Small Cities program addresses the community development needs of communities smaller than those eligible for the entitlement program.

Other CDBG programs, such as the Indian tribes and Alaskan native villages programs, target specific types of communities or activities.

Emergency Shelter Grants (ESG)

The Emergency Shelter Grants (ESG) program provides funds to States, metropolitan cities, urban counties, and Territories to improve the quality of existing emergency shelters and transitional housing for homeless people, to help create additional emergency shelters, for the payment of certain operating and social service expenses in connection with the homeless shelter, and for homeless prevention activities. ESG funds are targeted specifically to people who are homeless or at risk of homelessness and, unlike Shelter Plus Care funds, are not intended solely for homeless people who have disabilities.

State government recipients of ESG funds must distribute the funds to local governments and nonprofit organizations to perform approved emergency shelter activities. Local government recipients of ESG funds may distribute the funds directly to nonprofits.

HOME Investment Partnerships Program

The HOME Investment Partnerships Program, a partnership among the Federal government, State and local governments, and nonprofit housing developers, allows communities the flexibility to prioritize and fund the housing activities (acquisition, rehabilitation, new construction, and rental assistance) that best meet local needs. HUD allocates funds by formula among eligible State and local governments, which are then able to provide assistance to local developers of low income housing. Assistance can come in the form of loans, advances, equity investments, interest subsidies, and other forms of HUD-approved investment.

In an effort to encourage affordable housing development by nonprofits, the HOME Program reserves a portion of its funding for community housing development organizations (CHDOs). Local jurisdictions must set aside a minimum of 15 percent of their HOME program funds for investment in HOME eligible housing that is developed, sponsored, or owned by CHDOs.

HOME-assisted housing must be either permanent or transitional housing, including single room occupancy housing, group homes, and permanent housing for disabled homeless persons. HOME funds may be used for homebuyer assistance and tenant-based rental assistance (TBRA). Participating jurisdictions are able to provide a preference for a specific category of individuals with disabilities (including HIV/AIDS), as long as that category fills an unmet need as identified in the jurisdiction's Consolidated Plan.

The Continuum of Care Planning Process and Its Programs

As part of its efforts to encourage the integration and coordination of community homeless assistance efforts, HUD has combined its three major competitive homeless assistance programs–Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation Program Single Room Occupancy Dwellings (SRO) Program–into one national competition. The Continuum of Care approach is part of a community's larger effort of developing a Consolidated Plan. Funding for Supportive Housing Program, Shelter Plus Care, and Section 8 SRO projects must be applied for within a Continuum of Care context.

The establishment of a Continuum of Care system involves a community-wide or region-wide process involving nonprofit organizations (including those representing persons with AIDS and other disabilities), government agencies, other homeless providers, housing developers and service providers, private foundations, neighborhood groups, and homeless or formerly homeless persons. The goal of this process is to implement a unified strategy for homeless assistance that will fill gaps in local housing and service provision through the utilization of Federal, State, local, and private resources.

In some communities, the Continuum of Care planning process occurs annually at the time of developing the required Federal application. The first exhibit in the Continuum of Care application is the Continuum of Care narrative. It describes the planning process, the existing network of services and identified gaps, and relates the projects in the application to the needs and gaps. In other communities, a separate Continuum of Care Plan has been developed and Continuum of Care planning occurs year round, with the annual application process as one component of a broader community effort.

Supportive Housing Program (SHP)

The Supportive Housing Program (SHP) provides grant funds to public entities and private nonprofit organizations to supply community-based housing and supportive services to people who are homeless. Homeless individuals and families, including those who have a disability such as HIV/AIDS, are eligible to receive transitional housing, permanent housing, and supportive services.

SHP is designed to promote the development of housing and services that assist homeless persons in living as independently as possible. Applicants may propose funding in one (or in rare instances, more than one) of the five program components described below:

1. *Transitional housing*. Facilitates the movement of homeless individuals and families to permanent housing within 24 months. This temporary housing is combined with supportive services to enable homeless individuals and families to live as independently as possible.

2. *Permanent housing for homeless persons with disabilities*. Provides long-term housing for homeless persons with disabilities, including persons with HIV/AIDS. Housing is combined with supportive services to enable homeless persons with disabilities to live as independently as possible in a permanent setting.

3. *Supportive services only (SSO)*. Provides services designed to address the special needs of homeless persons who are not provided housing by the SSO project sponsor.

4. *Safe havens.* Provides a structure or a clearly identifiable portion of a structure that may supply the following:
   - Services for hard-to-reach homeless persons with severe mental illnesses who are on the streets and have been unwilling to participate in supportive services;
   - Twenty-four hour residence for an unspecified duration;
   - Private or semiprivate accommodations;
   - Common use of kitchen facilities, dining rooms, and bathrooms; and
   - Overnight occupancy limited to twenty-five or fewer persons.

   A safe haven may also provide supportive services on a drop-in basis to eligible persons who are not residents.

5. *Innovative supportive housing*. Enables applicants to design programs that are outside the scope of the other program components just listed. Applicants must demonstrate how the project takes a different approach when viewed within its geographic area, and how the project could be replicated.

Shelter Plus Care

The Shelter Plus Care program provides rental assistance for permanent housing, linked with supportive services funded by other resources, to homeless and disabled people and their families.

The four components of the Shelter Plus Care program are designed to give applicants flexibility in providing housing for homeless persons with disabilities and to ensure the accessibility of supportive services. With the exception of the single room occupancy (SRO) or efficiency units, assisted units may be of any type, ranging from group homes to apartments. The four components are:

1. *Tenant-based rental assistance (S+C/TBRA)*. Program participants choose the housing in which they would prefer to live, and the rental assistance remains with the participants if they decide to move to a different housing unit.

2. *Project-based rental assistance (S+C/PBRA)*. The recipient of the funds enters into a contract with an owner of an existing structure who agrees to rent units in the building to eligible people for a five- or ten-year period in exchange for receiving rental assistance payments. The rental assistance is based in the building that is receiving S+C/PBRA funds, and does not shift if the tenant decides to move to a new housing unit.

3. *Sponsor-based rental assistance (S+C/SBRA)*. Provides rental assistance through contract with a nonprofit organization, called a sponsor. A sponsor may be a private, nonprofit organization or a community mental health agency established as a public nonprofit organization. The sponsor implements the rental assistance program in property that it either owns or leases. Program participants must live in the unit in the assisted property and cannot shift the assistance if they decide to move.

4. *Section 8 Moderate Rehabilitation Assistance for Single-Room Occupancy Dwelling (S+C/SRO)*.[21] Funds are used to provide rental assistance to eligible individuals for single-room occupancy housing (including dwelling units that are not required to have food preparation or sanitary facilities) which is in need of moderate rehabilitation. Program participants must remain in the SRO structure to receive rental assistance.

[21] The S+C/SRO program differs in certain key ways from the Section 8 Moderate Rehabilitation/SRO Program. In particular, Shelter Plus Care specifically targets homeless people who have disabilities; also, Shelter Plus Care projects must include a supportive services component whereas Moderate Rehabilitation/SRO residents must be able to live independently.

Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings (SRO) Program

The Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings (SRO) Program provides rental assistance to homeless people residing in privately owned, rehabilitated SRO properties.[22] Under the SRO program, HUD contracts with public housing agencies (PHAs) to enable the moderate rehabilitation of residential properties that, when rehabilitation is completed, will contain multiple single room dwelling units. The PHAs make rental assistance payments to landlords on behalf of the homeless individuals who rent the rehabilitated dwellings, covering the difference between a portion of the tenant's income (normally 30 percent) and the HUD-established fair market rent (FMR) of the unit. Program stipulations include the following:

- Funds are provided to PHAs to make rental assistance payments for a ten-year period to participating owners of SRO rental properties on behalf of the homeless people who rent the units.
- Property owners are required to perform a minimum of $3,000 of rehabilitation work per SRO unit to meet HUD's housing quality standards (HQS). Although the program does not provide financing for the rehabilitation of the property, a portion of the cost of the rehabilitated work is reflected in the rents.

[22] SRO housing is defined as a unit that may, but does not necessarily, contain a kitchen and/or a bathroom and is designed for occupancy by one person who must be capable of independent living.

HRSA/HAB CARE Act Programs and Planning Processes

Overview of the CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first authorized in 1990 and was reauthorized in 2000. The CARE Act represents the largest dollar investment made by the Federal government to date specifically for the provision of services for people living with HIV/AIDS (PLWH).

The CARE Act is intended to help communities and States increase the availability of primary health care and support services that enhance access to care for PLWH who fall through the public safety net. The goal is to reduce utilization of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic. Briefly, the Act directs assistance through the following channels:

Title I: Eligible Metropolitan Areas (EMAs) with the largest numbers of reported cases to meet emergency service needs of PLWH.

Title II: All States, the District of Columbia, eligible U.S. Territories to improve the quality, availability, and organization of primary health care and support services that enhance access to care to PLWH and their families.

Title III: Public and private nonprofit entities to support outpatient early intervention HIV services.

Title IV: Public and private nonprofit entities for projects to coordinate services to–and provide enhanced access to research for–children, youth, women, and families with HIV/AIDS.

Part F:

- Special Projects of National Significance (SPNS) to develop innovative models of HIV/AIDS care that have a strong evaluation component, with attention to replication of effective projects by other CARE Act programs;
- AIDS Education and Training Centers (AETC), to conduct education and training for health care providers; and
- HIV/AIDS Dental Reimbursement Program, to help cover the uncompensated costs of providing oral health treatment to patients with HIV.

The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau has responsibility for the implementation of the CARE Act. Within the HIV/AIDS Bureau, the Division of Service Systems (DSS) administers Titles I, II, and the AIDS Drug Assistance Program (ADAP). The Division of Community-Based Programs administers Titles III, IV, and the HIV/AIDS Dental Reimbursement Program. The Division of Training and Technical Assistance (DTTA) administers the AIDS Education and Training Centers (AETC) Program and technical assistance activities for the HIV/AIDS Bureau. The Bureau's Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program, and supports program-related research and evaluation to improve the delivery of HAB programs.

Guiding Principles for Ryan White CARE Act Programs

HRSA has established a goal of "100% access and 0 disparities" for all its programs, including the CARE Act. This goal requires achieving access to high quality health care for all persons and elimination of race, gender, and geographic disparities in health outcomes.

Supplementing this goal, HRSA's HIV/AIDS Bureau has outlined the following four principles with important implications for HIV/AIDS services in the coming years. They are guided by legislative requirements as outlined in the CARE Act and by HAB program requirements:

1. **Better serving the underserved in response to the HIV/AIDS epidemic's growing impact among underserved minority and hard-to-reach populations.** This requires programs to assess the shifting demographics of new HIV/AIDS cases in their area and adapt/change care systems to suit the needs of emerging communities and populations. In particular, a need exists to reach people living with HIV/AIDS who are not in care and to ensure the provision of primary medical care and supportive services, directly or through appropriate linkages.
2. **Ensuring access to existing and emerging HIV/AIDS treatments that can make a difference.** The quality of HIV/AIDS medical care–including combination antiretroviral therapies and phophylaxis/treatment for opportunistic infections–can make a difference in the lives of people living with HIV/AIDS. Programs should focus on ensuring that available treatments are accessible and delivered according to established HIV-related treatment guidelines/recommendations.
3. **Adapting to changes in the health care delivery system and the role of CARE Act services in filling gaps in care.** Programs need to consider how CARE Act services are utilized in filling gaps in care, including coverage of HIV/AIDS-related services within managed care plans (particularly Medicaid managed care) and coordination of CARE Act services with other funding sources.
4. **Documenting outcomes.** Policy and funding decisions at the Federal level are increasingly being determined by outcomes. Programs need to document the impact of CARE Act funds on improving access to quality care/treatment along with areas of continued need. Programs also need to ensure that they have in place quality assurances and evaluation mechanisms to assess the effect of CARE Act resources.

Titles I and II

CARE Act programs provide for local control of planning and service delivery. Community-based planning bodies under Titles I and II foster substantive involvement of PLWH in the planning of care delivery systems.

Overview of Title I Program

Title I funding provides formula and supplemental grants to EMAs that are disproportionately affected by the HIV epidemic. These areas are eligible for Title I formula grants if they have reported more than 2,000 AIDS cases in the preceding five years, and if they have a population of at least 500,000 (this provision does not apply to EMAs funded prior to FY 1997).

Grants are awarded to the chief elected official (CEO) of the city or county that administers the health agency providing services to the greatest number of PLWH in the EMA. The CEO must establish an HIV Health Services Planning Council that is representative of the local epidemic and includes representatives from specific groups such as health care agencies, housing providers, and community-based providers. At least 33 percent of members must be individuals receiving HIV-related services. The planning council sets priorities for the allocation of funds within the EMA, develops a comprehensive plan, and assesses the grantee's administrative mechanism in allocating funds.

Services funded under Title I include an array of primary care and support services designed to enhance access to primary care. Examples include outpatient and ambulatory health services including substance abuse treatment; case management; home health and hospice care; early intervention services such as outreach, HIV counseling, testing, and referrals; and others.

Providers may include public or nonprofit entities; private for-profit entities are eligible only if they are the only available provider of quality HIV care in the area.

Overview of Title II Program

All States, the Commonwealth of Puerto Rico, the District of Columbia, and the U.S. Territories are eligible to receive Title II grants. Title II grants are awarded to the State agency designated by the governor to administer Title II, usually the Health Department. These grants are awarded on a formula and discretionary basis to provide health care and support services for PLWH. In addition to the formula grants, States also receive funds earmarked to support AIDS Drug Assistance Programs (ADAPs). ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

Title II funds may be used to support a wide range of services, including home- and community-based health care and support services; HICCP, the health insurance continuum of coverage program; pharmaceutical treatments through ADAP; local consortia that assess needs and organize and deliver HIV services in consultation with service providers; and, health and support services provided directly by the State.

States can use a variety of service delivery mechanisms. Some States provide services directly, while others subcontract with local Title II HIV care consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops and delivers services for PLWH. A consortium must submit an application to the State assuring that it has done the following:

- conducted a needs assessment;
- developed a plan to meet identified needs;
- promoted coordination and integration of community resources addressing the needs of all affected populations;
- assured the provision of comprehensive outpatient health and support services; and,
- arranged to evaluate the success and cost-effectiveness of the consortium in responding to service needs.

Title II grantees are also required to convene PLWH and representatives of other CARE Act grantees, providers, and public health agencies to develop a Statewide Coordinated Statement of Need (SCSN).

States with more than one percent of the total U.S. AIDS cases reported during the previous two years must contribute their own resources to match the Federal grant, based on a yearly formula. The Federal grant amount to States, the Commonwealth of Puerto Rico, and the District of Columbia is determined by applying a formula, or grantees are awarded $100,000 if they have fewer than 90 estimated living AIDS cases or $250,000 if the State has at least 90 estimated living AIDS cases. There is no minimum grant amount for U.S. Territories.

Case Studies of Integration of Housing Planning between CARE Act and HOPWA

State of Washington

CARE Act Title II Grantee:	State of Washington, Department of Health
CARE Act Title II Jurisdiction:	Statewide (Clark, King, Island, and Snohomish counties also receive Title I funds or services)
FY 1999 Title II Funding:	$2,2933,765
HOPWA Grantee:	State of Washington, Department of Community, Trade, and Economic Development
HOPWA Jurisdiction:	Statewide (except Clark, King Island, and Snohomish counties)
FY 1999 HOPWA Funding:	$487,000
Population (1998): *Population living with AIDS (9/99)*	3,049,342 (outside Clark, King, Island, and Snohomish counties) 990 (outside Clark, King, Island, and Snohomish counties)

Coordination in Funding

Washington State uses a "Parity Model" for its distribution of CARE Act and HOPWA grant funds. The funds are allocated according to a basic formula: the number of people living with HIV/AIDS in each of six regions over a two-year period is converted into a proportion of the statewide total, then multiplied by the total amount of dollars available. CARE Act funds determined by this formula then are allocated through six AIDS system networks (AIDSNETS) to each of the 13 Title II consortia.

HOPWA funds are distributed by the State through AIDSNETS to each of the six regions, except those that are direct recipients of HOPWA grants. For example, King County (where Seattle is located), already receives HOPWA funds, and is not eligible for the State's HOPWA funds.

With this system of distribution, each region of the State receives a fair share of funds to support AIDS services. By spreading the wealth, so to speak, each region is able to provide housing and supportive services to its own residents who are living with AIDS, allowing PLWH to stay in their own communities rather than having to migrate to metropolitan areas. In addition, allowing people living with AIDS to remain in their own communities reduces the strain on AIDS housing and service systems in the State's larger and medium-sized cities.

Coordination in Planning and Decision-making

Once HOPWA and CARE Act Title II funds have been distributed to the six AIDSNET regions, the consortia within the regions are able to determine how funds from both sources are allocated. The consortia rely on a statewide AIDS housing plan for guidance, and each sets a different course in building regional AIDS housing continuums. This system allows for flexibility, as each AIDSNET region is able to decide how the region can most effectively assist its residents living with HIV/AIDS. This approach has resulted in a diversity of responses from the AIDSNET regions.

AIDS Housing Continuum

The majority of housing resources available in counties outside of EMAs are emergency shelters and a few transitional housing resources. Other housing assistance comes in the form of emergency financial assistance and short-term rent subsidies. Most communities have a small, fluctuating population of people living with AIDS, often not large enough to support a facility-based program, although some counties do have residential facilities.

Response to HAB Policy 99-02

The State of Washington Department of Health (DOH) acted quickly in response to the issuance of HAB Policy 99-02. In August 1999, DOH sent letters to each Consortium lead agency requesting compliance with the policy by October 1st. The transition went very smoothly with no consortia lead agencies reporting problems in finding resources for medium to long-term housing. DOH recommended and lead agencies agreed not to use Title II funds for rent security deposits due to the complexity of setting up revolving funds and assuring that clients have no direct access to these funds.

This smooth transition to the new HAB housing policy is likely due to the availability of HOPWA funds and the well-established relationship CARE Act-funded agencies have with HOPWA, as well as a standardized allocation process. In addition to the "normal" funding received by the State and the EMA, AIDSNET Regions 1 and 2 were awarded funds through the competitive HOPWA REACH Project at the same time as the new HAB housing policy became effective.

Boston, MA EMA

CARE Act Title I Grantee:	Boston Public Health Commission (BPHC)
CARE Act Title I Jurisdiction:	*Massachusetts counties:* Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester *New Hampshire counties:* Hillsborough, Rockingham, and Strafford
FY 1999 Title I Funding:	$10,647,381
HOPWA Grantee (EMA):	City of Boston, Department of Neighborhood Development DND)
HOPWA Jurisdiction(EMA):	*Massachusetts counties:* Suffolk, and parts of, Middlesex, Essex, Plymouth, Worcester, Norfolk, and Bristol *New Hampshire counties:* parts of Rockingham
FY 1999 HOPWA Funding (EMA):	$1,890,000
HOPWA Grantee (State)	Commonwealth of Massachusetts, Department of Public Health (DPH)
HOPWA Jurisdiction (State)	Anywhere in the State of Massachusetts but with stronger emphasis on areas not covered by the City of Boston EMA or the Providence, RI EMA.
FY 1999 HOPWA Funding (EMA):	$11,111,000
Population (1998) (EMA): *Population (1999) (State):*	5,633,060 6,175,169
Population living with AIDS (2/00): *Population living with AIDS (2/00):*	2,016 (City of Boston) 6,552 (Massachusetts)

Coordination in Funding

The Boston EMA works with a decentralized system in which each of the three separate grantees for HOPWA and CARE Act work as individual entities. The Boston Public Health Commission is responsible for the CARE Act Title I money, while the Massachusetts Department of Public Health and the City of Boston's Department of Neighborhood Development are responsible for HOPWA funding. Each of the three agencies provides funding for the Metropolitan Boston area, yet their catchment area also includes distinctly different communities. These non-congruent catchment areas create challenges in funding coordination. Within these parameters the three funding agencies are considering a number of suggestions to streamline future grant coordination efforts.

Coordination in Planning and Decision-making

Planning, prioritizing, and decision-making for CARE Act Title I funds is performed by the CARE Act Planning Council, which is organized under the Boston Public Health Commission. The 45-member council is comprised of individuals and agencies (including one

member from the Department of Public Health and Department of Neighborhood Development) from across the catchment area and currently has 41 percent consumers in its membership. Members are selected through independent nomination and planning council recruitment efforts and are appointed to the planning council by the mayor of Boston.

There are two ways in which the priority for the use of HOPWA funds are determined. 1)The Department of Public Health (DPH) has its own statewide HOPWA advisory council made up of 18 individuals that are appointed by the agencies or consortia they represent. Recommendations from the group are taken into account but the DPH has the final decision of how HOPWA dollars will be allocated. 2) The City of Boston allocates its HOPWA funding through the Department of Neighborhood Development (DND), which uses a competitive RFP process to distribute HOPWA funds. Teams of service providers and representatives from the alternate funding agencies review proposals, set priorities and make recommendations to DND for HOPWA funding.

AIDS Housing Continuum

Massachusetts is unique in that none of the HOPWA or CARE Act money that comes into the region is used for actual rental subsidies. AIDS service providers have created a strong alliance with Federal and State programs to cover the rental portion of the 1,189 housing subsidies (project- and tenant-based subsidies) that are set aside for people living with HIV/AIDS within the three agencies' catchment areas. This means that all of the HOPWA and CARE Act money available from the three above-mentioned agencies is used for supportive services. These services include housing search, case management, and emergency and short-term rental assistance.

Consumers may self–refer to HIV/AIDS housing, however, due to the complex nature of the housing system, use of a case manager or housing advocate is encouraged. Consumers must provide individual programs with documentation of their HIV status and proof of low income status. Each agency has its own intake system, however in 1996 a universal application was created so that one preliminary application could be completed in order to apply to all of the HIV/AIDS housing programs in the State.

Response to HAB Policy 99-02

Because the EMA was using CARE Act funds only for eligible activities under HAB Policy 99-02 prior to the policy's issuance, only minor changes were implemented. A documentation of "medical need" form was developed, and the EMA continues to comply in paying for only short-term financial assistance. In addition to further collaboration, the feasibility of a joint RFP process between the three funding agencies is being explored.

Dallas, TX EMA

CARE Act Title I Grantee:	Dallas County Health and Human Services
CARE Act Title I Jurisdiction:	Collin, Dallas, Denton, Ellis, Henderson, Hunt, Kaufman, and Rockwall counties
FY 1999 Title I Funding:	$10,164,078
HOPWA Grantee:	City of Dallas (majority is subgranted to Dallas County Health and Human Services)
HOPWA Jurisdiction:	Collin, Dallas, Denton, Ellis, Henderson, Hunt, Kaufman, and Rockwall counties
FY 1999 HOPWA Funding:	$2,505,000
Population (1998): *Population living with AIDS (12/98)*	3,209,886 4,761

Coordination in Funding

The Dallas eligible metropolitan area (EMA) has separate grantees for CARE Act and HOPWA funding. The County of Dallas receives CARE Act Title I funding, while the City of Dallas receives HOPWA funding. However, the majority (approximately $2 million) of the formula HOPWA grant received by the city is subgranted to the county. Therefore, the Dallas County Health and Human Services receives and is responsible, with the direction of the CARE Act HIV Planning Council, for allocating the bulk of the AIDS-related Federal funding for the EMA.

Coordination in Planning and Decision-making

The Dallas CARE Act HIV planning council is the oversight body responsible for planning, prioritizing, decision-making, and, ultimately, allocating the majority of HOPWA and all of Title I funds. Two standing committees of the planning council, the Planning and Priorities Committee and the Allocations Committee, plan and set priorities for allocation decisions for Title I and HOPWA funds. Another standing committee of the council, Nominations, selects members of the community to nominate for membership. Nominations are reviewed by a Dallas County judge who selects and appoints nominees for membership.

People living with HIV/AIDS comprise over twenty-five percent of the CARE Act HIV Planning Council and are present on each standing committee. In addition, a committee of people living with HIV/AIDS has been formed to solicit input and recommendations from peers in the community. This committee also discusses and recommends improvements in HIV service delivery, such as quality assurance improvement and program evaluation.

AIDS Housing Continuum

The Dallas EMA uses its HOPWA funds to fund emergency, transitional, permanent, and specialized care housing options. Emergency assistance is available for short-term rent, mortgage, and utility payments. Transitional housing is available through multiple programs, including those that offer substance abuse treatment. Permanent housing assistance is available as tenant-based rental assistance and in facilities solely for people living with HIV/AIDS. Permanent housing options are also available for people with histories of substance abuse and those with mental health issues. In-home health care, hospice, and specialized care facilities are operated by multiple providers in the Dallas EMA.

Response to HAB Policy 99-02

Because the planning council plans, prioritizes, and allocates the two main Federal AIDS funding sources together, the EMA is able to act quickly and efficiently to make changes when new policies, such as HAB Policy 99-02, are issued. The Dallas EMA, prior to HAB Policy 99-02, funded some long-term congregate housing programs with Title I funds. In order to come into compliance with the new policy, the planning council decided to use HOPWA funds for this housing activity. Some supportive services that had been funded by HOPWA were shifted to Title I. This change in funding sources (see page 16, "Strategy B") was made simpler because of the structured coordination in the EMA between Title I and HOPWA funding sources, both at the grantee level (City and County of Dallas) and at the planning and decision-making level (HIV planning council).

Detroit, MI EMA

CARE Act Title I Grantee:	City of Detroit Health Department
CARE Act Title I Jurisdiction:	Six Counties including City of Detroit and Wayne County
FY 1999 Funding:	$6,900,000
HOPWA Jurisdiction:	Six Counties including City of Detroit and Wayne County
FY 1999 Funding amount:	$1,500,000
Population (1998): *Population living with AIDS (12/99)*	4,266,650 7,238

Coordination in Funding

The City of Detroit Health Department administers the CARE Act Title I, Title II, and HOPWA funds, as well as recently receiving funds through the Congressional Black Caucus State of Emergency program. The Administrator of HIV/AIDS programs supervises the staff for the three programs, who all work in the same division. In recent years, CARE Act funds have been allocated through an RFP process, while HOPWA funds have been allocated directly to a group of local housing providers to cover the housing continuum.

Coordination in Planning and Decision-making

The HIV planning council acts as an advisory body for Title I, Title II, HOPWA, and State funding for HIV services. Interested community members apply to the council for membership and appointments are confirmed by the mayor of Detroit. The council has several subcommittees including a Needs Assessment Committee, a Prioritization/Allocations committee, and a committee of members living with HIV/AIDS. A representative of the regional HUD offices sits on the planning council. The Prioritization/Allocations committee, which is composed of members with no conflict of interest, makes recommendations for the allocation of CARE Act funds. There is no separate housing committee. The information from the Needs Assessment is used to inform the HOPWA allocation, made by the Department of Health. When RFPs are used, the grantee assembles a panel, 25 percent of which comprises persons living with HIV/AIDS. The Health Department staffs a joint community planning process with both the CARE Act planning council and the local Prevention Council.

AIDS Housing Continuum

The Detroit EMA uses its HOPWA funds to fund a variety of ongoing housing programs, including a shelter operated by Health Care for the Homeless, transitional housing for families,

long-term rental assistance, and home care and assistance for people disabled with HIV/AIDS. Detroit has not historically used HOPWA funds for housing development, although renovation of an apartment building is currently underway. Approximately $100,000 of CARE Act funds have been allocated to housing, and have targeted one-time housing costs, such as move-in assistance. Coordination with the Consolidated Plan is occurring currently with the development of the new five-year plan.

Response to HAB Policy 99-02

Health Department staff have worked closely with their HRSA program officer to ensure that the use of CARE Act funds for move-in assistance, such as first and last months' rent and deposit, is in keeping with the HAB housing policy. The Department ensures that its providers do a housing assessment with every client and that they develop a housing plan. In addition to paying move-in costs, providers also deliver skill building and budgeting assistance services, and make sure that the clients receiving housing assistance are linked to primary care. The Department has also put in place mechanisms to recapture security deposits paid by the program, to make the funds available to another client.

San Francisco, CA EMA

CARE Act Title I Grantee:	City and County of San Francisco Health Department
CARE Act Title I Jurisdiction:	San Francisco City and County, San Mateo County, Marin County
FY 1999 Funding:	$36,218,513
HOPWA Grantee	City of San Francisco Redevelopment Agency
HOPWA Jurisdiction:	San Francisco City and County, San Mateo County, Marin County
FY 1999 Funding amount:	$7,207,910
Population (1998): *Population living with AIDS (1998)*	1,683,309 (745,774 in City of San Francisco) 9,292 (8,452 in City of San Francisco)

Coordination in Funding

Within the City of San Francisco, HOPWA funds are administered by the Redevelopment Agency, and CARE Act funds are administered by the Department of Public Health. However, funding allocations are discussed extensively to ensure that each funding source is used for its most suitable purpose and that the growing continuum of housing can be maintained. As an example of funding coordination, HOPWA funds are used to support the operations of five licensed AIDS care facilities, but the Home Health care services at the sites are covered by CARE Act. HOPWA funds are awarded by a Loan Committee which includes representatives of the San Francisco City Redevelopment Agency, the Office of Housing, the Department of Public Health; and the Mayor's Homeless Coordinator; and two members of the HIV Health Services planning council. The Redevelopment Agency Commission approves all allocations and awards.

Coordination in Planning and Decision-making

CARE Act funds are allocated by the HIV Health Services planning council. Interested community members apply to the council for membership, and the mayor of San Francisco confirms appointments. A housing subcommittee of the planning council is chaired by planning council members, but is open to all housing providers and consumers. Housing issues and recommendations for HOPWA are discussed at the council and within the subcommittee, but planning council recommendations are advisory to the Redevelopment Agency. Redevelopment Agency and Public Health Department staff sit on the planning council together.

The City of San Francisco has a city-wide AIDS Housing Plan which is used to inform decisions about CARE Act and HOPWA funds for housing. The recent update of the five-year plan focused in particular on obtaining consumer feedback and the process was linked closely with the PLWH caucus of the planning council.

In addition to HIV-specific coordination, San Francisco has a number of other bodies dedicated to coordinating housing issues. The current Consolidated Planning process includes a Supportive Housing subcommittee that is considering CARE Act and HOPWA within the context of supportive housing issues generally. As part of the Consolidated Plan process, an ad-hoc group is "re-envisioning emergency housing" on a citywide basis. A Continuum of Care addresses housing for homeless people throughout the city, and a "pipeline" team of city staff from various departments meets regularly to discuss shared roles and funding commitments for new housing projects in development, including staff administering CARE Act and HOPWA funds.

AIDS Housing Continuum

San Francisco has a full AIDS housing continuum, including emergency vouchers and detoxification beds (serving 829 households), transitional housing and residential drug and alcohol treatment (295 beds), rental assistance/subsidies (1022 units), permanent independent and congregate housing units (167), licensed residential care facilities (114 beds), and hospice and skilled nursing facilities (52 beds). More than 20 organizations provide housing or housing assistance to people living with HIV/AIDS. An HIV/AIDS housing waitlist facilitates entry into housing for people living with HIV/AIDS. More than 5,000 individuals have enrolled on the HIV/AIDS housing waitlist, and over 1,100 people have been placed in housing since its inception in 1995. Because need continues to outstrip the resources, most housing slots are targeted to persons who are homeless and disabled with HIV or AIDS.

Response to HAB Policy 99-02

San Francisco has the highest housing costs in the country, a vacancy rate below one percent and very little property that is able to be developed or is vacant. Most people living with HIV/AIDS in San Francisco have access to good medical and social services, but many lack access to affordable and safe housing or do not have adequate income to pay their rent. In such an extremely tight rental market, it is difficult even for individuals who do receive a rental subsidy to find safe and affordable housing. As of December 31, 1997 there were 7,963 people living with AIDS in San Francisco and more than 3,000 individuals on the HIV/AIDS housing waitlist in need of housing assistance.

Historically, San Francisco has primarily used HOPWA for development and CARE Act funds for services, but has also utilized both sources for rental assistance, in addition to city general funds. Rental assistance is a significant portion of the AIDS Housing Continuum, representing 1022 units. Based on the HAB Policy, San Francisco is reorienting the use of CARE Act funds for rental assistance to a temporary funder, prior to transitioning clients to HOPWA or general funds. However, the great demand and low turnover rates in the programs are making this transition difficult. Continuing increases in market rents and a jump of nearly 50% in the HUD allowable Fair Market Rents, which has made HOPWA funds more scarce, add to the difficulty. San Francisco is working closely with HRSA to address these issues and the Supportive Housing subcommittee of the citywide Consolidated Planning process is also addressing the rental assistance dilemma.

Technical Assistance

AIDS Housing of Washington National Technical Assistance Team

The mission of AIDS Housing of Washington's National Technical Assistance Team (NTAT) is to increase the quality and quantity of housing for people living with HIV/AIDS in the United States.

Founded in 1988, AIDS Housing of Washington (AHW) is recognized for developing innovative HIV/AIDS housing projects in the Seattle area. Bailey-Boushay House, the nation's first newly constructed skilled nursing residence and day health center for people living with AIDS, was built by AHW and is operated by Virginia Mason Medical Center. AHW also renovated the historic Lyon Building in downtown Seattle to create 64 units of permanent, supportive housing for individuals disabled with AIDS who also have histories of homelessness, mental illness, and/or substance abuse. Currently, AHW is engaged in a multi-year initiative to acquire condominiums and create set-asides in affordable housing projects being developed throughout King County. AHW staff have extensive experience with a range of funding mechanisms, financing strategies, and Federal programs for housing development and operations.

The NTAT, headed up by AIDS Housing of Washington, includes AIDS Housing Corporation (Boston), Technical Assistance Collaborative (Boston), Bailey House, Inc. (New York City), and the Corporation for Supportive Housing (which has a national program and field offices in California, Connecticut, Illinois, Michigan, Minnesota, New Jersey, New York, and Ohio.

Project-specific Technical Assistance to AIDS Housing and Service Organizations

Over the past eight years, AIDS Housing of Washington has provided project-specific technical assistance to HIV/AIDS housing providers in dozens of communities in more than 40 States. AHW is able to offer viable models around the country as examples for HIV/AIDS housing providers in virtually every situation–urban to rural settings, minority-based, and housing the most difficult to serve individuals and families, including chronically mentally ill, chemically addicted, homeless, and/or post incarceration.

Housing Development: AHW has expertise in all aspects of housing development including project conceptualization, siting, team building, budgeting, financing and construction.

Operations: AHW can offer both hands-on help and sample documents on such topics as policy and procedures manuals, property and asset management, grants management and reporting, and long-range planning.

Program Services: AHW recognizes the critical role of appropriate and effective support service delivery in assuring residential success. Assistance is available for program planning and development, best practices/operational models, serving diverse populations, and licensure.

Capacity Building: AHW is committed to providing board development training and assists boards and staff to assess organizational capacity including staff roles, adequacy of MIS, accounting, and other internal systems.

Partnerships: AHW facilitates the development of partnerships between AIDS service organizations and housing developers, which may include working with boards and staff of both organizations by identifying criteria for partnership, delineating organizational goals, and developing memoranda of understanding. Existing mainstream and low income housing providers and AIDS service organizations are encouraged to forge partnerships to capitalize on each other's strengths, connections, wisdom, and experience.

Comprehensive Strategies: Funding for development, operations, and support services comes from a wide range of sources, including the Housing Opportunities for Persons with AIDS (HOPWA) program of the U.S. Department of Housing and Urban Development (HUD) and the CARE Act programs of the U.S. Department of Health and Human Services (HHS). AHW can assist providers in developing strategies for and participating in Consolidated Plan, Homeless Continuum of Care, and CARE Act community-based planning activities.

Provider Education, Conferences, and Workshops

AIDS Housing of Washington staff have experience in providing training and technical assistance to State and local CARE Act and HOPWA coordinators and other government representatives, as well as a wide variety of community-based providers, including minority-based agencies, members of the affected communities and their advocates.

An integral part of our community-wide HIV/AIDS housing and services planning activities is training local providers on a range of topics, including the HIV/AIDS housing and care services continuums, HUD programs, program planning, housing development, property and asset management, budgeting, fundraising, operations, policies and procedures, and staffing.

AIDS Housing of Washington has conceived, organized, and convened three National HIV/AIDS Housing Conferences (1993, 1996, and 1998). Recognized as the primary source of continuing education in the AIDS housing field, the conferences have drawn approximately 750 participants from across the country and Puerto Rico, including AIDS housing providers, residents and advocates, planners, funders, HOPWA and CARE Act coordinators, and government representatives. The Fourth National HIV/AIDS Housing Conference is scheduled for June 2001.

In 1998, collaborating with HUD's Office of HIV/AIDS Housing, AHW began organizing an annual three-day meeting for the 97 cities and States that receive HOPWA formula funding. At both the conferences and grantee meetings, participants are offered multiple opportunities for skills building, networking, and input on policy development.

In collaboration with AIDS Housing Corporation, Bailey House, and the Corporation for Supportive Housing, AHW offers a range of training curricula which can be conducted in half-, one-, and two-day formats, depending on community/agency needs.

Training modules include:

- *Homeless Continuum of Care and Consolidated Planning;*
- *Community-based needs assessments and strategic planning;*

- *Fostering partnerships in AIDS housing development and operations;*
- *The essentials of supportive housing development;*
- *Developing and operating scattered-site housing programs;*
- *Serving residents with histories of chemical addiction and/or mental illness; and*
- *Asset management.*

Community-based Needs Assessments and Multi-year HIV/AIDS Housing Plans

AHW has pioneered and developed a particular expertise in community-wide approaches to HIV/AIDS housing and support service needs assessments and the development of multi-year HIV/AIDS housing plans. As AIDS housing and support service funds have leveled off, the need for cooperation across populations, interests, and areas of expertise has become more crucial. Proactive planning is critical to the creation and sustainability of a continuum of AIDS housing.

AHW's approach to needs assessment and planning is based in six primary principles:

- local support;
- consumer input;
- collaboration;
- partnerships;
- community involvement; and
- measurable outcomes.

AHW prefers to work in conjunction with a national intermediary or a strong local resource and, where possible, collaborates with other technical assistance providers. Broad community participation in the planning process is essential and includes government representatives, providers, people living with HIV/AIDS, and advocates. Finally, AHW develops plans that articulate short- and long-term needs, inventory existing housing and services, and state goals and objectives for the implementation process.

Communities where AHW has written and/or facilitated multi-year AIDS housing plans include Atlanta, Charlotte, Orange County, San Diego, Seattle, and St. Louis, as well as the States of Utah and Washington.

Publishing, Research, and Information Services

One of the strongest messages AHW has heard from providers and colleagues is the need for more written materials on key issues in the AIDS housing field. Towards that end, AHW has put increased emphasis on researching, producing, and disseminating resource materials. AHW is committed to making the best thinking, models, and practices of experienced AIDS housing providers publicly available. With its web site, www.aidshousing.org, AHW hopes to provide a national Internet clearinghouse for AIDS housing information and provider networking. In addition, AIDS Housing of Washington maintains the National HIV/AIDS Housing Providers Database, which profiles all known HIV/AIDS housing projects in the country.

AHW publications include:

- *Breaking New Ground: Developing Innovative AIDS Care Residences (*1993*);*
- *Financing AIDS Housing (*1998*);*
- *Rural AIDS Housing: Issues and Opportunities (*1998*);*
- *Reports from the First, Second, and Third National HIV/AIDS Housing Conferences (*1993, 1996, 1998*);*
- *Guide to Continuum of Care Planning and Implementation (*1999*);*
- *Effective Participation by the HIV/AIDS Community in HUD's Consolidated Plan (*1999*);*
- A set of pamphlets on optimizing public housing programs to better serve persons living with HIV/AIDS and their families; and
- AIDS Housing Monographs.

NTAT Partners' Contacts

Contact: Terra Chen
AIDS Housing of Washington
2025 First Avenue, Suite 420
Seattle, WA 98121
Tel: (206) 448-5242
Fax: (206) 441-9485
Email: info@aidshousing.org
Web: www.aidshousing.org

Contact: Soni Gupta
AIDS Housing Corporation
29 Stanhope Street
Boston, MA 02216
Tel: (617) 927-0088
Fax: (617) 927-9576
Email: sgupta@ahc.org
Web: www.ahc.org

Contact: Ryan Chavez
Bailey House
Technical Assistance Program and Evaluation Department
275 Seventh Avenue, 9th Floor
New York, NY 10001
Tel: (212) 633-2500
Fax: (212) 633-2932
Email: rchavez@baileyhouse.org
Web: www.baileyhouse.org

Contact: Suzanne Wagner
Center for Urban Community Services, Inc. (CUCS)
120 Wall Street, 25th Floor
New York, NY 10005
Tel: (212) 801-3300
Email: cucshrc.org
Web: www.cucs.org

Corporation for Supportive Housing
50 Broadway, 17th Floor
New York, NY 10004
Tel: (212) 986-2966
Email: information@csh.org
Web: www.csh.org

Contact: Emily Miller
Technical Assistance Collaborative, Inc.
One Center Plaza, Suite 310
Boston, MA 02108
Tel: (617) 742-5657
Email: emiller @tacinc.org
Web: www.tacinc.org

CARE Act Technical Assistance Program

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, administered by the Health Resources and Services Administration (HRSA), funds primary medical care and support services for low income, uninsured and underinsured persons with HIV disease. Technical Assistance (TA) and training activities to support CARE Act grantees and programs are directed through the HIV/AIDS Bureau's (HAB) Division of Training and Technical Assistance (DTTA).

The DTTA administers both on-site TA and various TA products. On-site TA is provided by peers (individuals who currently work in CARE Act-funded programs or are members of HIV Health Services planning councils and HIV Care Consortia) and other professional consultants. TA products include written reports, local and national TA conference calls and conferences, training videos, manuals, and self-assessment modules.

Technical Assistance Philosophy

TA is provided to CARE Act grantees and their HIV planning bodies with the goal of improving health care access and quality of life for persons who are infected with or affected by HIV disease. TA is provided to assist programs–not do the work of the TA recipient–and is provided to:

- assure compliance with legislative and HRSA requirements;
- ensure that grantees achieve a basic level of functioning; and
- assist grantees in addressing the following four principles that guide the CARE Act mission and programs:
  1. The HIV/AIDS epidemic is growing among traditionally underserved and hard-to-reach populations.
  2. The quality of emerging HIV/AIDS therapies can make a difference in the lives of people living with HIV disease.
  3. Changes in the economics of health care are affecting the HIV/AIDS care network.
  4. Policy and funding increasingly are determined by outcomes.

Technical Assistance is Provided Through:

- HRSA/HAB Federal project officers.
- A Technical Assistance Contract (TAC) that provides on-site consultation and coordinates the development of TA products.
- Cooperative agreements with national AIDS organizations that provide an avenue for HIV information exchange, including broader dissemination of HAB program goals and products through their members or affiliate organizations. These organizations also produce technical assistance monographs or manuals and assist with training on HIV care access issues.
- Consultation meetings with grantees, providers, representatives of professional and political organizations, and advocacy groups.
- A *Managed Care Training and Technical Assistance Program* designed to: 1) enhance the capabilities of CARE Act grantees to participate in managed care; 2) build collaborative relationships among State Medicaid officials, managed care plans, CARE Act funded providers, Federal staff, consumers, and other key stakeholders; and 3) assure that PLWH will continue to have appropriate access to managed care services.
- Interagency agreements that promote Federal HIV technical assistance collaboration.

To request TA, grantees should contact their HAB Federal project officer.

Technical Assistance Topic Areas

TA is provided in areas related to the legislative mandates and programmatic requirements of the CARE Act. Sample TA areas include but are not limited to the following:

- Access to Care
- Adolescent Development
- Case Management
- Comprehensive Planning
- Conflict of Interest
- Cultural Competency
- Evaluation and Outcome Measures

- Fiscal/Program Management
- Full and Effective Participation of PLWH in Program Implementation
- Grievance Procedures
- Managed Care
- Management Information Systems
- Needs Assessment
- New Treatment Advances and Clinical Guidelines
- Planning Council/Consortia Development
- Primary Care
- Unit Cost Development

Technical Assistance Inquiries

Contact your HAB project officer or
Nancy Kilpatrick, Chief, TA Branch
Division of Training and Technical Assistance
HIV/AIDS Bureau, HRSA
5600 Fishers Lane, Room 7-36
Rockville, MD 20857
301-443-9091; Fax: 301-594-2835
nkilpatrick@hrsa.gov

Media Inquiries

Tom Flavin, Director
Office of Communications
and Information Dissemination
HIV/AIDS Bureau, HRSA
5600 Fishers Lane
Rockville, MD 20857
301-443-6652; Fax: 301-443-0791
tflavin@hrsa.gov

AIDS Housing Resources

The list below comprises literature relevant to the AIDS housing field, and is divided into ten categories: Advocacy, Back to Work, Capacity Building, Changing Epidemic, Collaboration, Evaluation, Financing AIDS Housing, Harm Reduction, Operations, and Resident Involvement. This list is not comprehensive, although these resources should assist you in your efforts to increase the quality and quantity of AIDS housing in your area.

To order any of the resources, please contact the responsible organization directly.

Advocacy

1998 Advocate's Resource Book, National Low Income Housing Coalition, 1998.

Creating Change: A Guide for Local Action on Federal Housing Programs, National Low Income Housing Coalition, 1995.

National Low Income Housing Coalition
1012 14th Street, NW, #1200
Washington, DC 20005
(202) 662-1530 (x234)
www.nlihc.org

Community Change: How to Tell and Sell Your Story: A Guide to Developing Effective Messages and Good Stories about Your Work, Center for Community Change, 1998.

Center for Community Change
1000 Wisconsin Avenue
Washington, DC 20007
(202) 342-0567
www.communitychange.org

Opening Doors: Influencing Affordable Housing Decisions in Your Community, Technical Assistance Collaborative and Consortium for Citizens with Disabilities Housing Task Force, September 1997.

Consortium for Citizens with Disabilities
1730 K Street, NW, Suite 1212
Washington, DC 20006
(202) 785-3388
www.c-c-d.org

Back to Work

Next Door: A Concept Paper for Place-based Employment Initiatives, Corporation for Supportive Housing, 1998.

Next Stop: Jobs. Supportive Housing-Based Employment Assessment Tool, Corporation for Supportive Housing, 1997.

Corporation for Supportive Housing
50 Broadway, 17th Floor
New York, NY 10004
www.csh.org

Red Book on Work Incentives: A Summary Guide to Social Security and Supplemental Security Income Work Incentives for People with Disabilities, Social Security Administration (SSA), 1998.

Government Printing Office
(888) 293-6498
www.ssa.gov

Return to Work Issues for Persons Living with HIV and AIDS: A Health and Medical Checklist, National AIDS Fund, 1997.

Return to Work Issues for Persons Living with HIV and AIDS: A Self Assessment Tool, National AIDS Fund, 1997.

National AIDS Fund
(888) 234-AIDS
www.aidsfund.org

Returning to Work with HIV/AIDS, Mobilizing Talents and Skills, 1998.

Mobilizing Talents and Skills
38 East 29th Street
New York, NY 10016
(212) 679-8234

Capacity Building

A Time to Build Up, Corporation for Supportive Housing, 1998.

Corporation for Supportive Housing
50 Broadway, 17th Floor
New York, NY 10004
www.csh.org

Federal Compliance Issues for Nonprofits, The Enterprise Foundation, 1995.

- Enterprise Resource Center
  10227 Wincopin Circle, Suite 500
  Columbia, MD 21044-3400
  (410) 964-1230

Guide to Fundraising for Rural Nonprofits: Strategies for Raising Operating Funds, Housing Assistance Council, 1998.

Housing Assistance Council
1025 Vermont Avenue NW, Suite 606
Washington, DC 20005
(202) 842-8600
www.ruralhome.org

Changing Epidemic

A Guide to Developing Scatter Site Programs, Bailey House, 1998.

Bailey House, Inc.
275 Seventh Avenue, 12th Floor
New York, NY 10001
(212) 633-2500

Bringing Excellence to Substance Abuse Services in Rural and Frontier America, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1997.

National Clearinghouse for Alcohol and Drug Information
(800) 729-6686
TDD (800) 487-4889

HIV/AIDS Surveillance Report, 1998 Mid-year Edition, Centers for Disease Control and Prevention, 1999.

Trends in the HIV and AIDS Epidemic, Centers for Disease Control and Prevention, 1998.

National HIV Prevalence Surveys, 1997 Summary, Centers for Disease Control and Prevention, 1998.

National Prevention Information Network
P.O. Box 6003
Rockville, MD 20849-6003
www.cdc.gov

Rural AIDS Housing, AIDS Housing of Washington, 1998.

AIDS Housing of Washington
2025 First Avenue, Suite 420
Seattle, WA 98121
(206) 448-5242
www.aidshousing.org

Rural Homelessness: Focusing on the Needs of the Rural Homeless, U.S. Department of Agriculture, Rural Economic and Community Development, 1996.

Rural Housing Service
U.S. Department of Agriculture
14th St. and Independence Ave., SW,
Washington, DC 20250-0701
(202) 690-1533

Collaboration

Nonprofit/For-Profit Joint Ventures in Rural Affordable Housing: Case Studies, Housing Assistance Council, 1997.

Housing Assistance Council
1025 Vermont Avenue, NW, Suite 606
Washington, DC 20005
(202) 842-8600
www.ruralhome.org

Non-Profit Mergers: The Board's Responsibility to Consider the Unthinkable, National Center for Nonprofit Boards, 1994.

Seven Steps to a Successful Nonprofit Merger, National Center for Nonprofit Boards, National Center for Nonprofit Boards, 1996.

The Power of Mergers: Finding New Energy Through Mission-Based Restructuring, National Center for Nonprofit Boards, 1997.

National Center for Nonprofit Boards
2000 L Street, NW, Suite 510
Washington, DC 20036-4907
(800) 883-6262
www.ncnb.org

Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing, Corporation for Supportive Housing, 1997.

Corporation for Supportive Housing
50 Broadway, 17th Floor
New York, NY, 10004
www.csh.org

Perspectives on Partnerships, Ford Foundation, 1996.

Ford Foundation
320 East 43rd Street
New York, NY 10017
(212) 573-5169.

Evaluation

A Field Guide to Outcome-based Program Evaluation, The Evaluation Forum, 1998.

Managing the Transition to Outcome-based Planning and Evaluation, The Evaluation Forum, 1998.

Outcomes for Success, The Evaluation Forum. Outcomes for Success-Funders Edition, The Evaluation Forum, 1998.

The Evaluation Forum
1932 First Avenue, Suite 403
Seattle, WA 98101-1040
(206) 269-0171

Doing It Best: The Practice of Supportive Housing for Persons with HIV/AIDS in Massachusetts, AIDS Housing Corporation, 1997.

AIDS Housing Corporation
95 Berkeley Street
Boston, MA 02116-6229
(617) 451-2248
www.ahc.org

Outcomes Evaluation Technical Assistance Guide: Primary Medical Care Outcomes, HRSA HIV/AIDS Bureau, 2000.

HRSA HIV/AIDS Bureau
HRSA Information Center
5600 Fishers Lane, 7-46
Rockville, MD 20857
(888) ASK-HRSA
www.hrsa.gov/hab

Financing AIDS Housing

A Developer's Guide to the Low Income Housing Tax Credit (3d Edition), National Council of State Housing Agencies, 1996.

State Housing Trust Funds: Innovative Sources for Financing Affordable Housing, National Council of State Housing Agencies, 1993.

National Council of State Housing Agencies
444 North Capitol Street, NW, Suite 438
Washington, DC 20001

Breaking New Ground, AIDS Housing of Washington, 1993.

Financing AIDS Housing, AIDS Housing of Washington, 1998.

AIDS Housing of Washington
2025 First Avenue, Suite 420
Seattle, WA 98121
(206) 448-5242

Guide to Federal Funding for Governments and Nonprofits, Government Information Services, 1997.

Government Information Services
4301 North Fairfax Drive, Suite 875
Arlington, VA 22203-1627
(703) 528-1000

Utilizing the Low Income Housing Tax Credit for Rural Rental Projects: A Guide for Nonprofit Developers, Housing Assistance Council, 1997.

Housing Assistance Council
1025 Vermont Avenue, NW, Suite 606
Washington, DC 20005
(202) 842-8600
www.ruralhome.org

Harm Reduction

Exploring the Issue of Substance Use Vis-à-Vis HOPWA and Fair Housing Regulations, AIDS Housing of Washington, 1997.

AIDS Housing of Washington
2025 First Avenue, Suite 420
Seattle, WA 98121
(206) 448-5242
www.aidshousing.org

Harm Reduction, Gilford Press, 1998.

Harm Reduction: Come As You Are, Addictive Behaviors Research Center, 1996.

Alan Marlatt, Ph.D.
Addictive Behaviors Research Center
Department of Psychology, Box 351525
University of Washington
Seattle, WA 98195-1525
weber.u.washington.edu/~abrc/

HIV Law Today-A Survival Guide to the Legal System for People Living with HIV, Paul Hampton Crockett, 1997.

HIV Law Today
www.hivlawtoday.com
or bookstores.

HIV/AIDS and Homelessness

HIV/AIDS and Homelessness: Recommendations for Clinical Practice and Public Policy, Dr. John Song, Health Care for the Homeless Clinician's Network, Supported by HRSA's HIV/AIDS Bureau and Bureau of Primary Health Care, 1999.

Health Care for the Homeless
Clinician's Network
P.O. Box 60427
Nashville, TN 37206
(615) 226-2292
www.nhchc.org

Operations

Beyond Housing: Profiles of Low-Income, Service-Enriched Housing for Special Needs Populations and Property Management Programs, The Enterprise Foundation, 1997.

Enterprise Resource Center
10227 Wincopin Circle, Suite 500
Columbia, MD 21044-3400
(410) 964-1230

Confronting the Management Challenge: Affordable Housing in the Nonprofit Sector, Community Development Research Center, 1994.

The Robert J. Milano Graduate School of Management and Urban Policy
66 Fifth Avenue, Room 813
New York, NY 10011
(212) 229-5415

Getting Started, The Corporation for AIDS Research, Education, and Services, Inc. (CARES), 1996.

The Corporation for AIDS Research, Education, and Services, Inc. (CARES)
Executive Park Drive
Albany, NY 12203

Managing Housing for Low Income Persons with AIDS: Issues and Responses for Non-Profit Housing Providers, West Hollywood Community Housing Corporation, 1994.

West Hollywood Community Housing Corporation
8285 Sunset Boulevard, Suite 3
West Hollywood, CA 90046
(323) 650-8771

Operations Manager's Workbook, Bailey House, 1998.

Bailey House, Inc.
275 Seventh Avenue, 12th Floor4
New York, NY 10001
(212) 633-2500

The Program Director's Workbook: Tools for Implementing HIV Supportive Housing, AIDS Housing Corporation, 1995.

AIDS Housing Corporation
95 Berkeley Street
Boston, MA 02116-6229
(617) 451-2248
www.ahc.org

Resident Involvement

How to Set Up a Resident Advisory Council at Your AIDS Housing Program, AIDS Housing Corporation, 1998.

AIDS Housing Corporation
95 Berkeley Street
Boston, MA 02116-6229
(617) 451-2248
www.ahc.org.

Glossary

Affordable Housing

Housing is generally defined by the U.S. Department of Housing and Urban Development (HUD) as affordable when the occupant is paying no more than 30% of his or her adjusted gross income for housing costs, including utilities. Affordability is defined as a percentage of household income compared to the area average median income. Housing is typically considered "affordable" for households with incomes up to 80% of the average median income.

AIDS

Acquired Immunodeficiency Syndrome. A disease caused by the human immunodeficiency virus.

Assisted Living

Assisted living facilities are group residences that offer the delivery of professionally managed personal and health care services, including meals, 24-hour attendant care, social activities, assistance with bathing, dressing and transferring, dispensing medication, and health monitoring. Assisted living is intended for those who need some assistance in performing the activities of daily living but who do not need the heavy medical supervision provided by a skilled nursing facility. Assisted living facilities may be HIV/AIDS-specific, or they may serve many needs.

At Risk of Becoming Homeless

A person or family on the brink of homelessness due to inadequate income or paying too high a percentage of income on rent (typically 50 percent or more).

Beds

The unit of measure when describing the housing capacity or availability for skilled nursing facilities, hospices, board and care, adult family living, assisted living, and other such facilities.

Case Management

A range of client-centered services that link clients with health care, psychosocial services, and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and revision of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

Consolidated Plan

A document written by a State or local government and submitted annually to HUD that serves as the planning document of the jurisdiction and an application for funding under any of the community planning development formula grant programs (CDBG, ESG, HOME, HOPWA). The document describes the housing needs of the low and

moderate income residents of a jurisdiction, outlining strategies to meet the needs and listing all resources available to implement the strategies.

Continuum of Care (HRSA)

An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of people living with HIV/AIDS.

Continuum of Care (HUD)

An approach that helps communities plan for and provide a full range of emergency, transitional, and permanent housing and service resources to address the various needs of homeless persons. The approach is predicated on the understanding that homelessness is not caused merely by a lack of shelter, but involves a variety of underlying, unmet needs–physical, economic, and social. Designed to encourage localities to develop a coordinated and comprehensive long-term approach to homelessness, the Continuum of Care consolidates the planning, application, and reporting documents for HUD's Shelter Plus Care, Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings (SRO) Program, and Supportive Housing Program.

Cost Burden

The extent to which gross housing costs, including utility costs, exceed 30% of gross income, based on data published by the U.S. Census Bureau.

EMA/EMSA

Eligible Metropolitan (Statistical) Area. Geographic areas designated by population and cumulative AIDS cases to receive Federal funds through the CARE Act (EMA) and Housing Opportunities for Persons with AIDS (HOPWA) Program (EMSA).

Emergency Housing Assistance

Emergency housing assistance is provided to address an immediate housing crisis, often for people who are homeless or at imminent risk of becoming homeless. The primary goal of emergency assistance is to solve the immediate housing crisis. The assistance is usually one of the following: emergency rent, mortgage or utility payments to prevent loss of residence, motel vouchers; and/or emergency shelter. For CARE Act programs, the assistance must, among other requirements, be necessary to gain or maintain access to medical care. (The definition varies for HRSA and HUD; read program regulations.)

Emergency Shelter

Any facility with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for the homeless in general or for specific populations of the homeless.

Extremely Low Income

An individual or family whose income is between 0% and 30% percent of the median income for the area, as determined by HUD.

Fair Market Rent (FMR)

Rents set by HUD for a State, County, or urban area that defines maximum allowable rents in subsidy programs.

Groups Housing/Shared Living

Two or more single adults, or families with children, sharing living arrangements in a house or an apartment. Generally, individuals each have a bedroom and share a kitchen, bath, and housekeeping responsibilities. The group facility may provide a limited range of services and be licensed or unlicensed. Group housing may be transitional or permanent.

HAART

Highly Active Anti-Retroviral Therapy. The preferred term for potent anti-HIV treatment. This means a combination of drugs (usually three or more) to combat HIV. Usually more than one class of drug is included in a HAART regimen.

HIV

Human Immunodeficiency Virus. The virus that causes AIDS. People infected with HIV may or may not feel or look sick.

HOME

HOME Investment Partnership Program. A HUD-administered program providing grants for low income housing through rental assistance, housing rehabilitation, and new construction.

Homeless Family with Children

A family that includes at least one parent or guardian and one child under the age of 18; a homeless pregnant woman; or a homeless person in the process of securing legal custody of a person under the age of 18. Also see "homeless person."

Homeless Person

An unaccompanied youth (17 years or younger) or an adult (18 years or older) without children, who is not incarcerated and 1) who lacks a fixed, regular, and adequate nighttime residence; or 2) whose primary nighttime residence is a supervised publicly- or privately-operated shelter, an institution that provides a temporary residence for individuals intended to be institutionalized, or a public or private place not designed for regular sleeping accommodation for human beings.

Homeless Youth

A homeless person 17 years of age or younger who is unaccompanied by an adult.

HOPWA

Housing Opportunities for Persons with AIDS. A HUD program which pays for housing and support services for people living with HIV/AIDS and their families. Created by an Act of Congress in 1990.

Hospice

Hospice is a type of support and care provided to people in the last phases of an incurable disease so that they may live as fully and comfortably as possible. Hospice focuses on alleviating pain and discomfort, improving the quality of life, and preparing individuals mentally and spiritually for their eventual death.

Household

A household consists of all the people who occupy a housing unit. A house, an apartment or other group of rooms, or a single room, is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters; that is, when the occupants do not live and eat with any other persons in the structure and there is direct access from the outside or through a common hall.

A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household.

Housing Unit

An occupied or vacant house, apartment, or a single room (SRO housing) that is intended as separate living quarters (U.S. Census definition).

Housing Quality Standards (HQS)

Standards set by HUD to ensure that all housing receiving HUD financial assistance meets a certain level of quality. HQS requires that HUD funding recipients provide safe and sanitary housing that is in compliance with state and local housing codes, licensing requirements, and any other jurisdiction-specific housing requirements.

Housing Referral Services

Assistance to individuals who are having a difficult time finding and/or securing housing. According to HAB Policy 99-02, activities may include housing assessment, search, placement, and advocacy services. These activities must be provided by case managers or other professionals who possess a comprehensive knowledge of local, State, and Federal housing programs and how they can be accessed.

HUD

U.S. Department of Housing and Urban Development.

Low Income Family

A family whose income does not exceed 50% of the median income for the area, as determined by HUD, with adjustments for smaller and larger families. HUD may establish income ceilings higher or lower than 50% of the median for the area on the basis of HUD's findings that such variations are necessary because of prevailing levels of construction costs or fair market rents, or unusually high or low family incomes. (Definitions vary; read program regulations.)

Median Income

Median income is the specific income value that divides a population's income distribution into two equal groups, where half have incomes above that amount and half have incomes below that amount. The medians for households, families, and unrelated individuals are based on all households, families, and unrelated individuals, respectively. The medians are based on people with income who are 15 years of age or older.

Permanent Housing

Housing intended to be the tenant's home for as long as he/she chooses. In the supportive housing model, services are available to the tenant, but accepting services cannot be required of tenants or in any way impact their tenancy. Tenants of permanent housing sign legal lease documents.

Person with a Disability

A person who is determined to: 1) have a physical, mental, or emotional impairment that is expected to continue and be of indefinite duration, substantially impedes his or her ability to live independently, and is of such a nature that the ability could be improved by more suitable housing conditions; or 2) have a developmental disability, as defined in the Developmental Disabilities Assistance and Bill of Rights Act.

Project-based Rental Assistance

Rental assistance that is tied to a specific unit of housing, not a specific tenant. Tenants receiving project-based rental assistance give up the right to that assistance upon moving from the unit. See definitions for "rental assistance" and "tenant-based rental assistance."

Rental Assistance

Cash subsidy for housing costs provided as either project-based rental assistance or tenant-based rental assistance. HOPWA short-term rental assistance is available for up to 21 weeks. HOPWA long-term rental assistance is provided for longer than 21 weeks. Due to HOPWA regulations, rental assistance cannot be guaranteed for longer than three years. See HAB Policy 99-02 for guidance on CARE Act CARE Act rental assistance allowances. See definitions for "project-based rental assistance" and "tenant-based rental assistance."

Renter

A household that rents the housing unit it occupies, including units both rented for cash and occupied without cash payment of rent (U.S. Census definition).

Renter-occupied Unit

Any occupied housing unit that is not owner-occupied, including units rented for cash and those occupied without payment of cash rent.

Social Security Disability Insurance (SSDI)

SSDI is a Federal Government benefit for individuals who are medically disabled and have worked for enough years to be covered under Social Security.

Supplemental Security Income (SSI)

SSI is a Federal Government benefit for individuals who are 65 or older, blind, or have a disability and earn a low income.

Supportive Housing

Housing, including housing units and group quarters, that includes on- and off-site supportive services. See "supportive housing services," below.

Supportive Housing Services

Services provided to residents of supportive housing for the purpose of facilitating the independence of residents. Some examples are case management, medical or psychological counseling and supervision, child care, transportation, and job training.

Tenant-based Rental Assistance

A form of rental assistance in which the assisted tenant may move from a dwelling unit with a right to continued assistance. The assistance is provided for the tenant, not any specific housing unit. See definitions for "rental assistance" and "project-based rental assistance."

Transitional Housing

A project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to long-term housing. (Definitions vary. Read program regulations, including HAB Policy 99-02 for the CARE Act.)

Evaluation Form

Housing Is Health Care: A Guide to Implementing the HIV/AIDS Bureau (HAB) Ryan White CARE Act Housing Policy

After reviewing the document, please take some time to fill out this evaluation form. Your comments are of critical importance in our efforts to improve this draft document. Please mail, fax, or email your completed form to:

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Name: _____

Title: _____

Jurisdiction (EMA or state): _____

Guide Learning Goals

1. The Guide was:
   ____very useful to me
   ____somewhat useful to me
   ____not very useful to me
2. What specific things did you learn from this Guide that you can apply on the job?
   a.
   b.
   c.

Guide Content

3. How well did this Guide meet your expectations?
   not at all 1 2 3 4 5 extremely well
4. How well was the content organized?
   not at all 1 2 3 4 5 extremely well
5. Did the content of the Guide flow logically?
   not at all 1 2 3 4 5 very much so
6. Was the content appropriate for your skill/ experience level?
   not at all 1 2 3 4 5 very much so
7. Did the content of the Guide address the key issues facing you and/or your community?
   not at all 1 2 3 4 5 very much so
8. What did you like best about this Guide?
9. What did you like least about this Guide?
10. Other comments?

Housing Is Health Care – *Housing and the CARE Act*

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HIV/AIDS Bureau

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