

HOPWA TOOLKIT



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HOPWA FACT SHEET

HOPWA PROGRAM ELIGIBILITY

In order to be eligible for HOPWA services, a consumer must provide documentation to verify their HIV/AIDS status, income status and residency. Eligibility must be established prior to enrollment.

Certain HOPWA housing providers have additional eligibility requirements (i.e. mental health diagnosis, substance abuse diagnosis, age, history of incarceration, family with children, etc.) and require additional verification.

Medical Documentation

To verify HIV/AIDS diagnosis prior to program enrollment, a consumer or their medical provider must submit at least one of the below acceptable forms of documentation:

- Human Resources Administration (HRA) Medical Request for Home Care MIIQ form
- Laboratory results containing Viral Load and CD4 values
- Letter confirming HIV or AIDS diagnosis from a physician on letterhead with the physician's license number and signature
- ADAP (AIDS Drug Assistance Program) card

Income Documentation

Acceptable income documentation to verify program eligibility prior to enrollment include the following:

| Household income document type | Specific household income document | Household income document type | Specific household income document |
|---|--|---|---|
| Acceptable documentation for household income earned through wages: | <ul style="list-style-type: none"> • Pay stubs, earnings statement or W-2 form • Tax form (1040/1040A) showing amount earned and employment period • Notarized Income Verification form | Acceptable documentation for other forms of household income include: | <ul style="list-style-type: none"> • Alimony statement • Child support documentation • Documentation regarding contributions or gifts received from organizations or persons not residing in the household • Statements of income received for real or personal property; • Statements of interest/dividends obtain • Documentation of pay and allowances of a member of the Armed Forces |
| Acceptable documentation for government benefits and/or assistance: | <ul style="list-style-type: none"> • Federal and State Supplemental Security Income (SSI) or Social | Acceptable documentation for zero income: | <ul style="list-style-type: none"> • Notarized Zero Income Affidavit |

| | | | |
|--|---|--|--|
| | <ul style="list-style-type: none"> Security Disability Insurance (SSDI) award letters Veteran's Affairs award letter Unemployment, disability or worker's compensation Human Resources Administration (HRA) award letter(s), including <ul style="list-style-type: none"> HIV/AIDS Services Administration (HASA) award and/or Rent Payment Responsibility letters Public Assistance award letters | | <ul style="list-style-type: none"> Medical certification letter of the consumer's inability to work Letter from registrar's office confirming full-time enrollment |
|--|---|--|--|

Proof of Residency

Per contract requirements, an individual must be a New York City resident (living in the five boroughs: Brooklyn, Bronx, Manhattan, Queens or Staten Island) at/or upon program enrollment. Proof of residency must be obtained within 30 days of program enrollment. Proof of residency can include:

- Government issued photo identification card
- Rental or lease agreement
- Car registration
- Notarized affidavit of residency
- Any City, County or Federal government benefits card or letter
- Any bill that includes the name and address of the consumer. Examples include utility, phone, mobile phone, cable, internet, hospital, clinic or credit card bills

Certification of Homelessness

- Prior to program enrollment, all HOPWA housing providers must verify housing status for persons applying for HOPWA housing assistance and supportive services, where applicable.
- Housing status verification forms (one signed by the consumer and one by the HOPWA provider) with appropriate definitions of homelessness per U.S. Department of Housing and Urban Development (HUD) guidelines must be completed and maintained for all consumers.
Refer to Program Policy Guidance No. 2013-01 and 2013-02

Supplemental Eligibility Information

HOPWA housing providers that serve specific populations have further eligibility requirements. In addition to the previously mentioned program eligibility requirements, documentation specific to the population served must be obtained to verify program eligibility.

| Specific population | Additional required documentation | Specific population | Additional required documentation |
|---|--|---|--|
| Single adults or families: | Confirmation of Single or family status <ul style="list-style-type: none"> Federal, state or city identification cards, birth certificates, NYC HRA benefit card; Medicaid card | Single adults diagnosed with mental illness: | Mental health history <ul style="list-style-type: none"> Mental health/psychosocial assessment/evaluation; documentation of mental health diagnosis from mental health provider; toxicology results |
| Single adults/families who are ineligible for | Non-HASA eligibility <ul style="list-style-type: none"> Passport and/or expired visa copy, current letter | Single adults diagnosed with substance abuse: | Substance use history <ul style="list-style-type: none"> Documentation of substance use |

| | | | |
|--|--|---|--|
| HASA financial assistance: | from legal representation affirming non-PRUCOL status, documentation from HASA verifying non-eligibility | | treatment from facility or from medical provider; psychosocial assessment; toxicology results |
| Single adults recently released from correctional facility or institution: | Incarceration history <ul style="list-style-type: none"> Department of Corrections release/discharge planning form/aftercare letter | Single young individuals between the ages of 18 through 26: | Verification of age <ul style="list-style-type: none"> Birth certificate; current passport; federal, state or city identification cards |
| Single adults 55 years and older: | Verification of age <ul style="list-style-type: none"> Birth certificate; Medicare card; Medicaid card; federal, state or city identification cards | | |

REMINDER:

- All required eligibility documentation must be obtained prior to enrollment in the HOPWA housing providers.
- If a consumer is unable to work due to a medical condition, the consumer must submit a notarized Zero Income Affidavit **and** a letter from their medical provider verifying that the consumer is unable to work. The letter must be submitted annually until the consumer's medical situation changes.
- If a consumer is unable to work due to little or no work opportunities, the consumer must submit a Zero Income Affidavit.
- If the consumer is unable to provide paystubs or other employer documentation to verify income sources, the consumer can complete a Notarized Income Verification form and submit it annually.
- Collaterals or consumers aged 18 years and over must submit income documentation. If they are enrolled in a full-time continuing education program, they must submit a letter from the registrar's office indicating full time enrollment. If they do hold an income earning job, they need to submit appropriate proof of income documentation.

QA Tips!

- All income documentation must be dated and is only valid for up to one year. Please note, to continue receiving HOPWA services, consumers must provide income documentation annually to remain eligible in the program.
- Medical documentation must be dated within the 180 days of enrollment into the program. Afterwards, consumers are required to provide proof of engagement in HIV primary care, including copies of HIV-specific laboratory tests performed every 180 days.

Income /Self-Employment Verification



Instructions: Please complete the following form if you are employed but **DO NOT** receive pay stubs **OR** you are self-employed. This form must be notarized and returned to your Program on a yearly basis, at minimum, upon re-certification. Please keep a copy for your records.

I, _____(insert name), residing
at _____, _____, New York, _____
(Street Address, Apt. #) (City) (Zip code)

hereby certify that:

- I am self-employed as _____(insert occupation), *OR*
- I am employed as _____(insert occupation), for
_____ (Name of Company/Employer).

The income I receive from this employment is: \$ _____(per month).

Consumer Signature

Date

**I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in this program, and may be grounds for termination of assistance.*

Subscribed and sworn before me this _____ day of _____, _____.
(day) (month) (year)

Notary Public Seal



Notary Public Signature

ZERO INCOME AFFIDAVIT
HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

I, _____, have applied for housing assistance through the U.S. Department of Housing and Urban Development (HUD) Housing Opportunities for Persons with AIDS (HOPWA) program. Program regulations require verification of all income from participating households.

Income includes but is not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
- Net income from operation of a business or from rental or real personal property
- Interest, dividends and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
- Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609 (b)(5))
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)
- Regular monetary gifts from family and/or friends

I, _____ (first, last name) have stated during this income verification process that I have no income at this time. I have not received income since _____ (date).

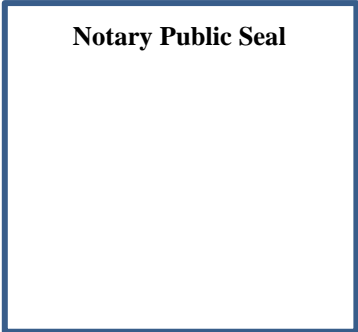
I do not expect to receive any income until _____ (date). I applied for _____ (other financial assistance) on _____ (date).

**I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in this program, and may be grounds for termination of assistance. I also certify that the above information is true and correct and that it is my responsibility to report all changes to my household composition and/or income in writing within ten (10) business days of such change.*

Consumer Signature: _____ Date: _____

Subscribed and sworn before me this _____ day of _____, _____
(day) (month) (year)

Notary Public Signature





New York City Department of Health and Mental Hygiene
Housing Opportunities for Persons With AIDS (HOPWA) Program

Client Certification of Homelessness/Imminent Risk of Homelessness

I, _____ certify that I/my family am/are homeless or at imminent risk of becoming homeless as categorized by the following:

Category 1- Literally Homeless

- I am an individual/family whose nighttime residence is a public or private place not meant for human habitation.
- I am an individual/family who currently lives in a public or privately owned shelter designated to provide temporary living arrangements (which may be a congregate shelter, transitional housing, or a hotel/motel paid for by a charitable organization or by federal, state, or local government programs).
- I am an individual/family exiting an institution where I/we resided for 90 days or less **and** resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Category 2- Imminent Risk of Homelessness

- The residence I/my family reside in will be imminently lost within 14 days of the date of application for homeless assistance, no subsequent residence has been identified, **and** I/my family lack the resources or support network needed to obtain other permanent housing.

Category 3- Homeless under other Federal Statutes

- I am an unaccompanied minor under 25 years of age or a family with children and youth who do not otherwise qualify as homeless under the definition outlined by the U.S. Department of Housing and Urban Development (HUD), but meet the criteria for homelessness as defined by other federal statutes. I have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; **and** I have experienced persistent instability as measured by two or more moves during the preceding 60 days **and** can be expected to continue in such status for an extended period of time due to special needs or barriers.

Category 4- Fleeing/Attempting to Flee Domestic Violence (DV)

- I/my family are fleeing, or attempting to flee a domestic violence situation, have no other residence, **and** lack the resources or support network to obtain other permanent housing.

I attest that the above information is accurate to the best of my knowledge and documentation of homelessness, where applicable, is attached. I understand the information provided above will be used to determine that I/my family are homeless based on the definitions outlined by the U.S. Department of Housing and Urban Development (HUD) and the New York City Department of Health and Mental Hygiene (DOHMH). Furthermore, I understand that failure to disclose all required information about my homelessness status will affect my ability to receive HOPWA-funded services and may lead to loss of program benefits.

Client Signature _____ Date ____/____/____



New York City Department of Health and Mental Hygiene
Housing Opportunities for Persons With AIDS (HOPWA) Program

Provider Certification of Homelessness/Imminent Risk of Homelessness

Agency Name: Date:
Staff Person: Position Title:

I, (Staff Person's Name) certify based upon my observation and/or documentation received that (Client's Name) is homeless or at imminent risk of becoming homeless based upon the circumstances indicated below:

Category 1- Literally Homeless

- The client/family's current primary nighttime residence is a public or private place not meant for human habitation.
The client/family currently lives in a public or privately owned shelter designated to provide temporary living arrangements...
The client is exiting an institution where s/he resided for 90 days or less and resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Category 2- Imminent Risk of Homelessness

- The client/family currently reside in a residence that will be imminently lost within 14 days of the date of application for homeless assistance, no subsequent residence has been identified and lacks the resources or support networks needed to obtain other permanent housing.

Category 3- Homeless under other Federal Statutes

- The client is an unaccompanied youth under 25 years of age or family with children and youth who do not otherwise qualify as homeless under the definition outlined by the U.S. Department of Housing and Urban Development (HUD), but meet the criteria for homelessness as defined by other federal statutes.

Category 4- Fleeing/Attempting to Flee Domestic Violence (DV)

- The client/family is fleeing, or attempting to flee a domestic violence situation, has no other residence, and lacks the resources or support network to obtain other permanent housing.

The above information is accurate to the best of my knowledge based upon observations and/or documentation provided by the individual/family. Documentation to support the client's classification of homelessness is attached, where applicable and/or available.

Staff Person's Signature: Date: / /



HOPWA FACT SHEET

ASSESSMENT AND REASSESSMENTS

HOPWA assessment/reassessments forms serve as a tool to identify, evaluate and document your consumer's supportive service needs. They also comprehensively capture a range of information to inform your service delivery and referrals.

The HOPWA assessment/reassessments forms capture information on housing status, household composition, income sources, entitlements, medical, behavioral/mental health needs, and medications. All tabs are required to be completed and updated according to the schedule described below.

Consumer needs identified in the assessment/reassessment are meant to inform your Service Plan development.

Contract Requirements: The initial assessment, which is conducted at intake, must be completed within 30 days of enrollment. Reassessments take place every 90 days thereafter. In total, your consumer should have at least four reassessments per year.

- All completed assessment/reassessments must be reported in eCOMPAS on a quarterly basis.
- Copies of completed assessments/reassessments must be present in the consumer record/chart.
- When entering the service in eCOMPAS, the total time entered should include the time it took to prepare, conduct and document the service.
- All assessments/reassessments should take place face to face with the consumer, unless otherwise noted by DOHMH.

REMINDER:

- If a consumer is unavailable to complete a reassessment when it is due, the reason must be documented in the service notes and updated in the Client Record Certification Form in eCOMPAS. The reason could be excused if the client has been hospitalized and/or institutionalized, therefore, unable to complete the scheduled reassessment. The reassessment should then be completed when the consumer is available. The following reassessment that is due should take place when due (every 90 days) and not delayed due to the previous late reassessment.

QA Tips!

- Ensure that all areas of the reassessment form are certified and updated in eCOMPAS.
- Any changes to consumer eligibility (i.e. income) or household composition identified during a reassessment should be reflected in the appropriate eCOMPAS assessment tabs as well as in a progress notes.

- If a consumer reports income changes during a reassessment, please remember to complete a new Resident Rent Calculator Worksheet.
- Regular primary care, emergency room visits, and hospitalizations are often forgotten, and therefore, must be entered in the required fields for all consumers who have a history of those types of incidences.

Program Staff are required to use the Assessment/Reassessment form to deliver personalized case management services to help their consumers achieve housing stability and access to care. The form can be found in eCOMPAS and in the HOPWA Toolkit.

HOPWA ASSESSMENT/REASSESSMENT FORM

(Please Print)

| | | | | |
|---|--|--|--|---|
| Today's date (MM/DD/YYYY): / / | Client ID (Agency Assigned): | E2ID (eCOMPAS ID): <input type="checkbox"/> Index <input type="checkbox"/> Collateral | | |
| GENERAL INFORMATION | | | | |
| Last Name (including suffix): | | First: Middle: | Date of birth (MM/DD/YYYY): / / | |
| Last Name at Birth (if different from above): | Social Security number: - - | Gender at birth: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Intersex | Current gender identity: <input type="checkbox"/> Male <input type="checkbox"/> Trans Male to Female <input type="checkbox"/> Female <input type="checkbox"/> Trans Female to Male <input type="checkbox"/> Unknown | |
| Sexual Orientation: <input type="checkbox"/> Gay/Lesbian/Homosexual <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer | | <input type="checkbox"/> Questioning <input type="checkbox"/> Other <input type="checkbox"/> Declined | Other known aliases used: | |
| Current Client Address | | | | |
| Street address: | | City, State: | Zip Code: | |
| Permanent Mailing Address <input type="checkbox"/> Same as Current Address | | | | |
| Street address: | | City, State: | Zip Code: | |
| Primary phone number: () | | Alternate phone number: () | Email: | |
| Emergency contact information | | | | |
| Contact Name: | | Relationship to client: | Home phone no.: () Alternate phone no.: () | |
| Race (select all that apply): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ | <u>Asian sub-category</u> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian | Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No | Employment Status: <input type="checkbox"/> Employed or self-employed <input type="radio"/> Full-time <input type="radio"/> Part-time <input type="checkbox"/> Out of Workforce (e.g. caretaker/retired) <input type="checkbox"/> Intermittently employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled for work <input type="checkbox"/> Unpaid volunteer/peer worker <input type="checkbox"/> Other (specify): _____ | Education: <input type="checkbox"/> No Schooling <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> Some high school <input type="checkbox"/> High school diploma or GED <input type="checkbox"/> Vocational training <input type="checkbox"/> Some college or technical school <input type="checkbox"/> College graduate <input type="checkbox"/> Bachelor's/ Technical degree <input type="checkbox"/> Postgraduate |
| | <u>Hawaiian/PI sub category</u> <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native American <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander | <u>Hispanic Ethnicity Category</u> <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Mexican, Mexican-American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latino/a, or Spanish origin | | |
| Primary Language Spoken (select only one): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Other (specify): _____ | | Country of birth: <input type="checkbox"/> USA <input type="checkbox"/> US Territory/Dependency (i.e. Puerto Rico) <input type="checkbox"/> Other (specify): _____ | Are you a veteran of the armed forces? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | |

Have you or anyone in your household ever experienced physical, sexual or emotional abuse by intimate partner/family member? Yes No Declined

Do you or anyone in your household currently have an Order of Protection or are you afraid of someone who has or might hurt you? Yes No Declined

Are you or anyone in your household currently fleeing due to domestic violence, sexual assault, or stalking? Yes No Declined

If **yes** to any of above, when was the last instance of abuse _____ / _____ / _____
MM DD YYYY

HOUSING INFORMATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|-----------------------------------|----------|----------------------|----------|--------------------|----------|--------------------|----------|----------|----------|-----------------------------------|----------|------------------------------|----------|-----------------------|----------|------------------------|----------|------|----------|-----|----------|-------------------|----------|-----|----------|------------------|----------|--------------------|----------|---------------|----------|---------|----------|---------------------------------|----------|
| <p>Have you received any income in the past 30 days?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>If yes, →</p> | <p>Please list amount you receive from each source each month:</p> <table border="0"> <tr> <td>Job earnings/wages</td> <td>\$ _____</td> <td>Veteran's Disability</td> <td>\$ _____</td> </tr> <tr> <td>HASA cash benefits</td> <td>\$ _____</td> <td>Private Disability</td> <td>\$ _____</td> </tr> <tr> <td>Odd jobs</td> <td>\$ _____</td> <td>Gifts from partner/friends/family</td> <td>\$ _____</td> </tr> <tr> <td>Public Assistance (non-HASA)</td> <td>\$ _____</td> <td>Worker's Compensation</td> <td>\$ _____</td> </tr> <tr> <td>Unemployment Insurance</td> <td>\$ _____</td> <td>TANF</td> <td>\$ _____</td> </tr> <tr> <td>SSI</td> <td>\$ _____</td> <td>Veteran's Pension</td> <td>\$ _____</td> </tr> <tr> <td>SSD</td> <td>\$ _____</td> <td>Pension from job</td> <td>\$ _____</td> </tr> <tr> <td>Retirement from SS</td> <td>\$ _____</td> <td>Child Support</td> <td>\$ _____</td> </tr> <tr> <td>Alimony</td> <td>\$ _____</td> <td>Other (<i>specify</i>: _____)</td> <td>\$ _____</td> </tr> </table> | Job earnings/wages | \$ _____ | Veteran's Disability | \$ _____ | HASA cash benefits | \$ _____ | Private Disability | \$ _____ | Odd jobs | \$ _____ | Gifts from partner/friends/family | \$ _____ | Public Assistance (non-HASA) | \$ _____ | Worker's Compensation | \$ _____ | Unemployment Insurance | \$ _____ | TANF | \$ _____ | SSI | \$ _____ | Veteran's Pension | \$ _____ | SSD | \$ _____ | Pension from job | \$ _____ | Retirement from SS | \$ _____ | Child Support | \$ _____ | Alimony | \$ _____ | Other (<i>specify</i> : _____) | \$ _____ |
| Job earnings/wages | \$ _____ | Veteran's Disability | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HASA cash benefits | \$ _____ | Private Disability | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Odd jobs | \$ _____ | Gifts from partner/friends/family | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Public Assistance (non-HASA) | \$ _____ | Worker's Compensation | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Unemployment Insurance | \$ _____ | TANF | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SSI | \$ _____ | Veteran's Pension | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SSD | \$ _____ | Pension from job | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Retirement from SS | \$ _____ | Child Support | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alimony | \$ _____ | Other (<i>specify</i> : _____) | \$ _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | |
|--|---|
| Total number of persons in household (including client): | Gross <u>household</u> monthly income (<i>income must be verified through documentation, e.g., Social Security Administration award letter, pay stubs, etc.</i>): |
| | \$ _____ |

Currently enrolled in the HIV/AIDS Services Administration (HASA) program? Yes No

Non-cash benefits (*check all that apply*):

| | | | |
|--|--|--|--|
| <input type="checkbox"/> Food Stamps/SNAP (\$ _____) | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare | <input type="checkbox"/> WIC |
| <input type="checkbox"/> SCHIP (Children's Health Program) | <input type="checkbox"/> VA Medical Services | <input type="checkbox"/> TANF transportation | <input type="checkbox"/> TANF Child Care |
| <input type="checkbox"/> Other TANF | <input type="checkbox"/> None | | |

Currently receiving Housing Subsidy? Yes No

If **yes**:

| | | | | |
|----------------------------------|------------------------------------|----------------------------------|-------------------------------|--|
| <input type="checkbox"/> HASA/PA | <input type="checkbox"/> Section 8 | <input type="checkbox"/> SLF/RAP | <input type="checkbox"/> VASH | <input type="checkbox"/> Other (<i>specify</i>): _____ |
|----------------------------------|------------------------------------|----------------------------------|-------------------------------|--|

Current living situation (*select one*):

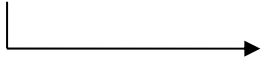
| | |
|---|--|
| <p><input type="checkbox"/> Place not meant for human habitation (e.g. street)</p> <p><input type="checkbox"/> Emergency shelter (non-SRO hotel)</p> <p><input type="checkbox"/> Single Room Occupancy (SRO) hotel</p> <p><input type="checkbox"/> Transitional Housing</p> <p><input type="checkbox"/> Temporarily staying in someone else's room, apartment, or house <i>Specify:</i> <input type="radio"/> Friends <input type="radio"/> Family</p> <p><input type="checkbox"/> Supportive Housing Program</p> <p><input type="checkbox"/> Rented room, apartment, or house (not affiliated with a supportive housing program)</p> <p><input type="checkbox"/> House you own</p> | <p><input type="checkbox"/> Hospital/Institution (<i>specify</i>):</p> <p style="margin-left: 20px;"><input type="radio"/> Hospital (non-psychiatric facility)</p> <p style="margin-left: 20px;"><input type="radio"/> Psychiatric hospital or other psychiatric facility</p> <p style="margin-left: 20px;"><input type="radio"/> Substance abuse treatment facility or detox center</p> <p><input type="checkbox"/> Jail, prison, or juvenile detention facility</p> <p><input type="checkbox"/> Foster care home or foster care group home</p> <p><input type="checkbox"/> Hotel or motel (paid for without emergency shelter voucher)</p> <p><input type="checkbox"/> Other (<i>specify</i>): _____</p> |
|---|--|

Start Month and Year of Current Housing Situation: MM/YYYY Unknown/declined

How long do you estimate to remain in your current situation?

- At least 1 year 1 month - <6 months
 6 months - <12 months <1 month

| | |
|---|--|
| Institutionalized in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes : <input type="checkbox"/> Prison, jail, or juvenile detention facility <input type="checkbox"/> Substance Abuse Treatment Facility <input type="checkbox"/> Psychiatric Hospital psychiatric <input type="checkbox"/> Hospital/Nursing home (excluding | If recently institutionalized, were you homeless (street, SRO or transitional housing) prior to institutionalization? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

| | | | | |
|--|--|--|--|---------------------------------------|
| At risk of becoming homeless in next 14 days? <input type="checkbox"/> Yes <input type="checkbox"/> No | Ever homeless on street, shelter, SRO, or transitional housing? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Start date of most recent date of homelessness? ____ / ____ / ____ <i>MM DD YYYY</i> | End date of most recent date of homelessness? ____ / ____ / ____ <i>MM DD YYYY</i> | Number of episodes (in past 3 years): |
|--|--|--|--|---------------------------------------|

Do you have any barriers that would limit your ability to live independently, including any physical disability, mental illness or substance use issues?
 Yes No

HOUSEHOLD INFORMATION

Note: Household is defined solely as those individuals who live with the index client. Each collateral is required to complete a separate intake.

| <u>Collateral Name</u> | <u>Relationship to client:</u> | <u>Intake completed?</u> | <u>HIV-positive?</u> |
|------------------------|--|---|--|
| 1. | <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Child <input type="checkbox"/> Partner/Guardian <input type="checkbox"/> Sibling <input type="checkbox"/> Other <i>(specify: _____)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 2. | <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Child <input type="checkbox"/> Partner/Guardian <input type="checkbox"/> Sibling <input type="checkbox"/> Other <i>(specify: _____)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 3. | <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Child <input type="checkbox"/> Partner/Guardian <input type="checkbox"/> Sibling <input type="checkbox"/> Other <i>(specify: _____)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 4. | <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Child <input type="checkbox"/> Partner/Guardian <input type="checkbox"/> Sibling <input type="checkbox"/> Other <i>(specify: _____)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

To enter additional collaterals, use additional blank copies of this page and attach them to the file.

GENERAL HEALTH

| | |
|--|---|
| Overall, in the past 3 months, how has your general health been? | <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
|--|---|

| | |
|--|--|
| Do you have any of the following medical conditions requiring treatment: | |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Heart disease/hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Hepatitis C | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |

| | |
|---|---|
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="radio"/> Active TB <input type="radio"/> Latent TB |
| Other(s) (<i>specify</i> : _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| If yes to any of the above conditions, are you currently receiving treatment for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Have you been diagnosed with a physical disability such as visual impairment, audio impairment, a physical impairment that affects your mobility, or any other physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | If yes , are you currently receiving treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Have you been diagnosed with a developmental disability such as Attention Deficit Disorder (ADD), autism, cerebral palsy, or any other developmental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | If yes , are you currently receiving treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |

MEDICAL INFORMATION

Health Insurance Status (check all that apply):

| | |
|--|--|
| <input type="checkbox"/> Medicaid or CHIP | Medicaid number: _____ |
| <input type="checkbox"/> Medicare | Medicare number: _____ |
| <input type="checkbox"/> ADAP/ADAP+ | ADAP/ADAP+ number: _____ |
| <input type="checkbox"/> Private | Medicaid Plan Types: <input type="checkbox"/> Special Needs Plan (SNP) |
| <input type="checkbox"/> Military, VA, Tricare | <input type="checkbox"/> Managed Care Organization (MCO) |
| <input type="checkbox"/> Uninsured | <input type="checkbox"/> Fee-for-service (FFS) |
| <input type="checkbox"/> Other (<i>specify</i>): _____ | <input type="checkbox"/> Not sure |

| | | |
|---|---|--|
| HIV Status: <input type="checkbox"/> HIV Positive <input type="checkbox"/> HIV Negative (only if collateral) <input type="checkbox"/> Unknown | → | If HIV negative , in the past 3 months, have you used PrEP to prevent yourself from becoming infected with HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure/never heard of Prep <input type="checkbox"/> Declined Date of last negative test (MM/DD/YYYY): / / |
|---|---|--|

Date of first positive HIV test (MM/DD/YYYY): / /

Are you: Asymptomatic Symptomatic

AIDS diagnosis: Yes No Unknown AIDS diagnosis date (MM/DD/YYYY): / /

Risk factors for HIV (check all that apply):

| | |
|--|---|
| <input type="checkbox"/> Blood transfusion, blood components or tissue | <input type="checkbox"/> MSM |
| <input type="checkbox"/> Hemophilia/coagulation disorder | <input type="checkbox"/> Perinatal |
| <input type="checkbox"/> Heterosexual contact | <input type="checkbox"/> Risk Factor not reported or not identified |
| <input type="checkbox"/> IDU | |

Do you have an HIV primary care provider? Yes No

| | | |
|------------------------------------|-----------------------------------|--|
| Hospital/Clinic/Office name: _____ | Medical provider last name: _____ | Date of last visit: (MM/DD/YYYY) : _____ |
|------------------------------------|-----------------------------------|--|

Do you currently have a case manager, care coordinator or patient navigator? Yes No

| | | |
|--------------|--------------------|---|
| Agency name: | Case manager name: | Date of last CM visit (MM/DD/YYYY): / / |
|--------------|--------------------|---|

| | |
|-----------------------------------|--|
| Are you enrolled in Health Homes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-----------------------------------|--|

CD4 INFORMATION

| | | | |
|-----------------------------|--|----------------------------|------------|
| Most recent CD4 Information | Data Source: <input type="checkbox"/> Lab results reviewed <input type="checkbox"/> Client self-report | Test Date (MM/DD/YYYY): | CD4 Count: |
|-----------------------------|--|----------------------------|------------|

VIRAL LOAD INFORMATION

| | | | | |
|------------------------------------|--|----------------------------|--|---|
| Most recent viral load information | Data Source: <input type="checkbox"/> Lab results reviewed <input type="checkbox"/> Client self-report | Test Date (MM/DD/YYYY): | Virally Suppressed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Viral Load Quantity (copies/mL): _____ |
|------------------------------------|--|----------------------------|--|---|

EMERGENCY ROOM VISITS/HOSPITALIZATIONS

| | |
|--|-------------------------------|
| Number of hospitalizations in the past six months: | <input type="checkbox"/> None |
|--|-------------------------------|

| Date (MM/DD/YYYY): | Hospital Name | Diagnosis: |
|--------------------|---------------|------------|
| 1. / / | | |
| 2. / / | | |
| 3. / / | | |

| | |
|--|-------------------------------|
| Number of Emergency Department / Emergency Room visits in the past six months: | <input type="checkbox"/> None |
|--|-------------------------------|

| Date (MM/DD/YYYY): | Hospital Name | Diagnosis: |
|--------------------|---------------|------------|
| 1. / / | | |
| 2. / / | | |
| 3. / / | | |

MEDICATION/ANTIRETROVIRAL TREATMENT

Currently prescribed HIV antiretroviral treatment (ART)? Yes No Declined

| | Currently prescribed HIV medication names | Frequency | Date Started (MM/DD/YYYY) |
|---|---|---|---------------------------|
| If NO on ART, go to next question about why client is not on ART | 1. | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| | 2. | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| | 3. | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| | 4. | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| | 5. | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| <i>To enter additional medications, use additional blank copies of this page and attach them to the file.</i> | | | |

| | |
|--|---|
| In the past 3 days (not including today) how many times did you skip a dose of HIV medication? | _____ # times <input type="checkbox"/> Declined |
| In the past 3 days (not including today) were you off schedule (late by an hour or more) in taking HIV medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Over the last six months, what was your general experience taking your HIV medications? | <input type="checkbox"/> Takes them exactly as prescribed, almost never missing a dose <input type="checkbox"/> Sometimes skips a dose or forgets to take pills <input type="checkbox"/> Often skips dose or forgets to take pills <input type="checkbox"/> Rarely takes pills as prescribed |

If **no** on ART, what is the main reason you are not currently prescribed ART? (check only one)
 Not medically indicated Not-ready, by PCP determination Intolerance/side effects/toxicity Client refused
 Not HIV Positive (for HIV-negative collaterals **only**) Payment/insurance/cost issue Other reason (*specify*: _____)
 Unknown

Are you currently taking any other prescribed medication? (this includes any medication for mental illness) Yes No Declined

| | Other medication names | Frequency | Date Started (MM/DD/YYYY) |
|----|------------------------|---|---------------------------|
| 1. | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| 2. | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| 3. | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| 4. | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| 5. | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| 6. | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| 7. | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |
| 8. | | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | ___/___/___ |

To enter additional medications, use additional blank copies of this page and attach them to the file.

| DRUG/ALCOHOL INFORMATION | | | |
|---|---|--|---|
| Substance | Have used in past 3 months? | | In the past 3 months, how often have you used? |
| | IF YES, THEN ASK → | | In the past 3 months, how have you taken this? (Check all that apply) |
| Tobacco | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of times daily or <input type="checkbox"/> Less than daily <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |
| Alcohol | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of drinks daily or _____ # of drinks weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined <i>Note: One drink is a 12 ounce beer or a 5 ounce glass of wine or one shot of liquor.</i> |
| Marijuana | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of times weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |
| Cocaine/Crack | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of times weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |
| Heroin | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of times weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |
| Crystal Meth | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of times weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |
| Prescription pills to get high (e.g. Valium, Klonopin, Oxycontin, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of times weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |
| Hallucinogens/LSD/PCP | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of times weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |
| Hormones/Steroids (e.g. Androgel, testosterone, etc.) | Prescribed by doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Both | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | _____ # of times weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |
| Anything Else: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined | | _____ # of times weekly or <input type="checkbox"/> Less than weekly <input type="checkbox"/> Not at all <input type="checkbox"/> Declined |

| DRUG/ALCOHOL INFORMATION | | |
|--|---|---|
| Have you ever injected any drug or substance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| If yes , have you ever shared needles or injection equipment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| If yes , in the past three months, have you shared needles or injection equipment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Admitted into an inpatient treatment program (e.g., detox, rehab, etc.) for alcohol use? | Ever? | Currently? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Admitted into an inpatient treatment program (e.g., detox, rehab, etc.) for drug use? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Attended an outpatient alcohol treatment program? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Attended an outpatient drug treatment/harm reduction program? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Attended a methadone/buprenorphine maintenance program? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BEHAVIORAL RISK REDUCTION | | |
| In the past 12 months, have you had vaginal or anal sex with anyone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| If yes to above question: | | |
| How many sexual partners have you had in the past 12 months? | _____ # of partners | <input type="checkbox"/> Declined |
| In the past 12 months, who have you had sex with? | <input type="checkbox"/> Men Only <input type="checkbox"/> Women Only <input type="checkbox"/> Both Men and Women | |
| In the past 12 months, have you had vaginal or anal sex without a condom with a person who was HIV positive? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| In the past 12 months, have you had vaginal or anal sex without a condom with a person who was HIV negative or whose HIV status you did not know? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| MENTAL HEALTH | | |
| Ever diagnosed with mental illness? (e.g., depression, bipolar disorder, anxiety disorder, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| If yes , please check all that apply: <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Depression <input type="checkbox"/> HIV-associated dementia <input type="checkbox"/> Personality disorder <input type="checkbox"/> Psychosis <input type="checkbox"/> PTSD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other (<i>specify</i> : _____) | | |
| If no , provider: Is there any documentation and/or evidence in client's records that indicate a history of mental illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ever hospitalized for psychiatric reasons? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Ever prescribed psychotropic medication for mental illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Currently receiving treatment for a mental illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| CHILDREN | | |
| Do any children under the age of 18 live in or regularly visit your home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| If yes to above question: | | |
| Have you or anyone in your household ever had a report made to or a case opened by the Administration for Children's Services (ACS)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |
| Would you be interested in getting help or support with parenting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Declined |



HOPWA FACT SHEET

HOUSING QUALITY STANDARDS (HQS)

HOPWA regulations specify that each housing unit supported with HOPWA funds must comply with Housing Quality Standards (HQS). HQS are housing regulations established by HUD that describe the minimum criteria necessary to provide decent, safe and sanitary housing. As such, all units must be compliant with state and local housing codes. To accomplish this, HOPWA housing provider staff should conduct online reviews of apartment and building violations before signing/renewing a lease using the following online databases:

- Department of Buildings (DOB)
- Housing Preservation & Development (HPD)
- Environmental Control Board (ECB)

If a violation is found, housing provider staff must contact the landlord to inquire the status of resolving the violation. This information should be documented along with requests for updates made until the violation is resolved.

HUD requires HOPWA housing providers to perform and document initial housing inspections when a consumer is first enrolled and conduct annual inspections thereafter. The HQS inspection form should include all areas reviewed including the living room, kitchen, bedroom(s) and bathroom(s). The report should address all areas in each room of the housing unit e.g. ceilings, walls, floors, windows, electrical, heating, etc. and the building's common areas should also be assessed. HQS inspection findings must be signed by HOPWA housing provider staff to certify habitability standards are being met in the units occupied by HOPWA consumers and saved in the consumer's record.

If any repair issues are identified during the inspection, program staff should assess the issue and determine if it is safe for the consumer to remain in the unit. The issue should be documented in the consumer's record and the necessary repair scheduled with the landlord or program's residence management department. In the case of a major repair issue, an inspection should be conducted afterward to assess if the repair was properly addressed and habitability standards continue to be met.

As part of DOHMH monitoring efforts of HQS requirements, the DOHMH Program Analyst will verify that each consumer record contains an HQS inspection report performed within the past 12 months (or at program enrollment for a new consumer).

REMINDER:

- Before a lease/tenancy agreement is signed, program staff are required to conduct an apartment inspection to assess HQS of a housing unit and address any issues. This must be conducted prior to the consumer moving in the unit.
- For consumers enrolled in a Housing Placement Assistance (HPA) contract, an HQS inspection must take place prior to placement as well as 30 days *after* the consumer has moved into the housing unit. A final HQS inspection must be performed before consumer case closure (at 12 months follow up).
- If a housing provider uses their agency's maintenance staff to complete repairs, a work order must be completed to document the issue and the outcome of the repair.
- As best practice, when conducting monthly home visits, providers are strongly encouraged to have the housing provider staff assess the condition of the housing unit and ask the consumer if there are any needed repairs between annual inspections.
- If a large repair issue occurs, housing provider staff should complete an HQS inspection once the repair is completed.



HOPWA FACT SHEET

INCOME RECERTIFICATION

The HOPWA housing provider must conduct annual recertification of household income as part of the overall annual recertification process to ensure consumer program eligibility. Income eligibility is based on the HUD income limits (which deems consumers eligible if they are at or below 50 percent of area median income), which are published annually based on household size. Income recertification takes place at minimum annually, and usually occurs 12 months after initial program enrollment.

Acceptable income documentation to verify program eligibility during the annual income recertification process includes the following:

| Household income document type | Specific household income document |
|--|---|
| Acceptable earned household income documentation: | <ul style="list-style-type: none"> • Pay stubs, earnings statement or W-2 form • Tax form (1040/1040A) showing amount earned and employment period • Notarized Income Verification form |
| Acceptable income documentation for government benefits and/or assistance: | <ul style="list-style-type: none"> • Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) award letters, including state portion (OTDA) • Veteran’s Affairs award letter • Unemployment, disability or worker’s compensation • Human Resources Administration (HRA) award letter(s) <ul style="list-style-type: none"> ○ HIV/AIDS Services Administration (HASA) award and/or Rent Payment Responsibility letters ○ Public Assistance award letters |
| Acceptable documentation for zero income: | <ul style="list-style-type: none"> • Notarized Zero Income Affidavit • Medical certification letter of the consumer’s inability to work, if applicable • Letter from registrar’s office confirming full-time enrollment for students |
| Acceptable documentation for other forms of income/earnings: | <ul style="list-style-type: none"> • Alimony statement/payment record • Child support documentation • Documentation regarding contributions or gifts received from organizations or persons not residing in the household • Statements of income received for real or personal property • Statements of interest/dividends obtain • Documentation of pay, special pay and allowances of a member of the Armed Forces |

REMINDER:

- If there is a change in household income during the annual income recertification period, the HOPWA housing provider must ensure the most current income information is updated in:
 - The consumer's Resident Rent Calculator Worksheet in order to calculate the correct consumer rent portion;
 - The Assignments tab of the HIMM; and
 - The Housing Status tab of the Reassessment.
- If a consumer is unable to work due to a medical condition, the consumer must submit a notarized Zero Income Affidavit **and** a letter from their medical provider verifying that the consumer is unable to work. The letter must be submitted annually until the consumer's situation changes.
- If a consumer is unable to provide paystubs or other employer documentation to verify income sources, the consumer can complete a Notarized Income Verification form and submit it annually.
- Collaterals or consumers aged 18 years and over must submit income documentation, if they are enrolled in full-time continuing education program, they do not need to submit proof of income but must submit a letter from the registrar's office indicating full time enrollment.

QA Tips!

- All income documentation must be dated and is only valid for up to one year. Please note, to continue receiving HOPWA services, consumers must provide income documentation annually to remain eligible in the program.
 - If the consumer's Resident Rent Calculator Worksheet is updated to reflect a change in household income and the result is a change in the consumer's rent portion, the following must be updated:
 - The consumer's Tenancy Agreement, which contains the consumer's rent portion
 - The Assignment in the HIMM
-

2020 FAIR MARKET RENT (FMR) & 2020 INCOME LIMITS

NEW YORK CITY

FY 2020 New York, NY HUD Metro Area Fair Market Rent (FMRs):

| # Of Bedrooms | Efficiency | One Bedroom | Two Bedroom | Three Bedroom | Four Bedroom |
|---------------|------------|-------------|-------------|---------------|--------------|
| FY 2020 FMR | \$1,665 | \$1,714 | \$1,951 | \$2,472 | \$2,643 |

FY 2020 New York, NY HUD Metro FMR Area Income Limit Area:

| Income Limit Category | 1 Person | 2 Person | 3 Person | 4 Person |
|-----------------------------------|----------|----------|----------|----------|
| Extremely Low (30%) Income Limits | \$23,900 | \$27,300 | \$30,700 | \$34,100 |
| Very Low (50%) Income Limits | \$39,800 | \$45,500 | \$51,200 | \$56,850 |
| Low (80%) Income Limits | \$63,700 | \$72,800 | \$81,900 | \$90,950 |



HOPWA FACT SHEET

INTAKE, CONSENTS & HIV CONFIDENTIALITY

Face Sheet

A face sheet is a document that briefly summarizes a consumer's most important information at a glance. The face sheet can include contact details, household composition, emergency contact, and other relevant data. The face sheet should be maintained in the beginning of the consumer's file, updated as changes occur and signed with dates.

Intake Form

The intake process occurs at the initial face-to-face encounter with the consumer. During intake:

- The HOPWA housing provider gathers information to address the consumer's immediate needs and to encourage his/her engagement and retention in supportive services.
- The consumer's information is captured in an intake form (some of this information may also be captured in the initial eCOMPAS Assessment form) and completed during the initial meeting with the consumer.

The intake form is an agency developed internal document. The form must be accurately completed and maintained in the consumer's chart.

Confidentiality, Grievance, and Termination Attestations

A copy of the agency's confidentiality, grievance and termination policies must be provided to each consumer during intake and annually thereafter. Policies must be signed and dated by consumers and appropriate housing provider staff within the 30-day enrollment period.

- The language in the policies must be plain and clear and if possible, available in multiple languages for the diverse consumer population.
- The housing provider must have the consumer sign and date each policy affirming the consumer has read and understood the confidentiality, grievance and termination policies.
- Alternatively, the consumer can affirm having acknowledged the policies by signing and dating separate attestations.
- The signed attestations or policies must always be maintained in the consumer's chart and a copy of the documents must be provided to the consumer
- HOPWA housing provider staff are also required to sign and date these attestations or policies along with each consumer.

Additionally, any changes/amendments to the policies requires the consumer review and signature.

HIPAA release form

The HIPAA (Health Insurance Portability and Accountability Act of 1996) is a federal law protecting the confidentiality of consumer health information by setting limitations on the disclosure and use of such information. The overall goal of the HIPAA is to securely facilitate the sharing of Public Health Information (PHI) between service providers. Under HIPAA, any PHI regarding a consumer's past, present and future medical condition(s) and care, may only be used and disclosed by covered entities with the consumer's written authorization.

Upon program enrollment, all HOPWA housing providers must obtain a HIPAA authorization to access and disclose PHI for the consumers they serve.

- A HIPAA authorization is more **customized, detailed and specific** than a general consent. It includes the uses, disclosures and the PHI stipulated in the authorization; it has an expiration date; states the purpose for which the information may be disclosed and to whom the information will be disclosed.
- HIPAA term dates must cover 12 months of the year or 365 days.
- The HIPAA form must be completed, signed and dated by all appropriate parties, and updated as soon as term dates expire and/or if any information changes (i.e., providers, contacts, etc.).
- HOPWA housing providers must follow all applicable confidentiality and privacy laws, including Federal (e.g., HIPAA), State (e.g., Article 27-F) and local laws in order to protect consumer privacy.
- HOPWA housing providers must have a detailed plan to ensure consumer privacy and confidentiality (including data quality and security) that is compliant with New York State Public Health and HIPAA laws.
- Federal regulations call for grantees such as DOHMH to ensure that all HIV/AIDS housing providers secure the confidentiality of all consumers receiving housing assistance, through ongoing training and monitoring.
 - All staff working under the HOPWA contract are required to complete the online HIV Confidentiality Training offered by DOHMH on an annual basis. To access the training, please visit: <https://training.nyecompass.com>

REMINDER:

- If a consumer is homeless at the time of intake, use 99999 for the zip code.
- If a consumer is undocumented, use 999-99-9999 for the social security number.
- The dates used to validate the HIPAA must be written in (not typed) at the time of signature by the consumer and appropriate HOPWA housing provider staff. Dates should not be written in or pre-typed prior to the date the consumer authorized the HIPAA.

QA Tips!

- The consumer's intake, initial assessment, service plan development and eligibility documentation must always be present in the consumer record.
- HIPAA forms must be updated every 12 months or 365 days.
- HOPWA housing providers must ensure to protect consumer confidentiality.
 - Consumer names and other identifiable information must never be used in email or reports shared with DOHMH. Instead, e2IDs must be used to protect such information.
 - Consumer records must be safely stored, and proper measures must be in place to ensure consumer identifiable information (e.g., names, etc) is not evident on binder/folder covers.
 - Providers should not text or email consumers via 'group texts/emails' in order to avoid confidentiality breaches.

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- My HIV-related information
- My non-HIV health information
- Both (non-HIV health and HIV-related information)

| |
|--|
| Name and address of facility/person disclosing HIV-related information: _____ _____ |
| Name of person whose information will be released: _____ |
| Name and address of person signing this form (if other than above): _____ _____ |
| Relationship to person whose information will be released: _____ _____ |
| Describe information to be released: _____ |
| Reason for release of information: _____ |
| Time Period During Which Release of Information is Authorized: From: _____ To: _____ |
| Exceptions to the right to revoke consent, if any: _____ _____ |
| Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences): _____ _____ |

| | |
|---|------------|
| Please sign below only if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services. | |
| Signature _____ | Date _____ |

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

**Authorization for Release of Health Information
and Confidential HIV-Related Information***

**Complete information for each facility/person to be given general information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

**Authorization for Release of Health Information
and Confidential HIV-Related Information***

**Complete information for each facility/person to be given general information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**



HOPWA FACT SHEET

TENANCY AND LEASE AGREEMENT

The purpose of tenancy and lease agreements is to ensure consumers' housing stability by outlining rights and responsibilities of consumers, HOPWA housing providers, and landlords.

Tenancy Agreement

A tenancy agreement, also called a sublease agreement, is the rental contract between the HOPWA Housing Provider and the Consumer. Tenancy agreements are applicable to Supportive Permanent Housing (SPH) programs (and in some cases, Housing Placement (HPA) programs if a consumer is placed in a supportive housing unit) only.

- A tenancy agreement contains specific program regulations and outlines the consumer's responsibilities as a tenant.
- The tenancy agreement must contain the unit's monthly rent, which must not exceed the Fair Market Rent (FMR), and clearly indicate the consumer's rent responsibility.
 - If the consumer's Resident Rent Calculator Worksheet is amended due to a change of income and the result is a change in the consumer's rent portion, then the consumer's tenancy agreement, which contains the consumer's rent portion amount, must also be updated.
- A tenancy agreement must contain a start date and end date covering a one-year term and must be updated annually.
- A tenancy agreement should also specify if the unit includes utilities or not. If not, the utility allowance amount should be included in the agreement.
- A tenancy agreement must be signed and dated by the consumer and housing provider staff.
- A copy of the tenancy agreement must be given to the consumer and a copy maintained in the consumer record.

Lease Agreements

A lease agreement is the rental contract between the HOPWA Housing Provider and the Landlord, or in Rental Assistance (REN) and Housing Placement Assistance (HPA) contracts the Landlord and the Consumer.

- The lease agreement will contain specific information valid only for the housing unit. A lease rider may accompany a lease.
- The lease must include a start and end date, the address of the unit and the name of the lease holder, whether it is the consumer (REN) or the housing provider.
- The lease must clearly state if utilities are included in the rent or whether they are the tenant's responsibility.
 - If utilities are included in the rent, the total monthly rent must not exceed the Fair Market Rent (FMR).
- Both the landlord and the tenant (Housing provider/Consumer) must sign the lease agreement, and the landlord must give the tenant a copy before the tenancy begins. The lease agreement sets forth the legal rights of both parties.
- Housing providers must ensure all consumers are stably housed by making sure all leases are renewed in a timely manner.
- Expired leases are considered a contract compliance issue, as HOPWA housing providers are required to ensure an executed renewed lease is in place prior to the lease expiration date.

- If the lease agreement has expired before the renewal has been executed due to extenuating circumstances (e.g., extended negotiations with landlords, severe unit repair/maintenance issues, etc), the lease agreement is considered month-to-month.
 - Lease terms should be entered every month in eCOMPAS in order to aid with maintaining accurate payment records until the renewal lease is executed.
-

REMINDER:

- Tenancy agreements and lease agreements are required for SPH programs.
 - Lease agreements, only, are required for Rental Assistance (REN) and Housing Placement Assistance (HPA) programs.
 - The unit lease renewal process must begin 90 days before lease expiration to allow for the transition of the lease terms and avoid unexpected interruptions (i.e. missing signatures, errors in lease terms, lost documents, etc.).
 - Consumer eligibility must be confirmed by housing providers before the consumer signs a new tenancy agreement.
 - Before signing a lease and the consumer moving into the unit, HOPWA housing providers must conduct an apartment inspection to assess Housing Quality Standards (HQS) and complete a search for violations. *Please reference the Housing Quality Standards fact sheet for more information.*
-

QA Tips!

- Once a consumer is placed in a housing unit, their address and current living situation must be updated in eCOMPAS.
 - Newly executed lease agreement terms must be added in eCOMPAS in the HIMM (Housing Inventory Management Module).
-



HOPWA FACT SHEET

MEDICAL RECERTIFICATION

One of the primary goals of the HOPWA housing provider is to ensure consumers are engaged and retained in HIV medical care. While completing reassessments (due every 90 days), program staff are required to monitor the consumer's engagement with medical care and their health outcomes. Consumers are asked to submit documentation from their medical providers at each reassessment (if applicable) and report on any Primary Care visits. Consumers who have collaterals that are HIV positive in their household must also submit medical documentation.

Some consumers may have laboratory tests completed once every three months, six months, 12 months, etc. These consumers should submit copies of the laboratory results to their case managers however often they have results, but at minimum once or twice a year.

All laboratory results and medical documentation received on behalf of the consumer must be stored in the consumer chart and entered in eCOMPAS.

Medical Recertification Requirements

The documentation the consumer must submit includes:

- Laboratory results containing Viral Load and CD4 values
 - Additionally, the documentation should contain at a minimum, the consumer's name, medical provider name and license number, if applicable, and medical facility name and location.
- Recent medical appointment summary from their HIV primary care doctor dated within the last 12 months, at minimum.

Virally Suppressed vs. Undetectable

The HOPWA program at DOHMH has implemented initiatives to increase the percentage of virally suppressed HOPWA consumers in NYC to 90% or higher. This goal is aligned with local (NYS Ending the Epidemic (EtE)), national (National HIV/AIDS Strategy), and international (UNAIDS) viral suppression targets.

Housing research studies demonstrate that stable permanent housing can lead to improved health outcomes among PLWHA. Therefore, housing providers are uniquely positioned to improve engagement in HIV care & viral suppression outcomes among PLWHA consumers they house and serve.

To track viral suppression outcomes of HOPWA consumers and ensure alignment with EtE efforts, data quality of laboratory results entered in eCOMPAS must be closely monitored by HOPWA housing providers.

Viral Suppression: When an individual's viral load is less than or equal to 199 copies per mL, they are considered virally suppressed. By taking their HIV medicines regularly, people living with HIV/AIDS can reduce the level of HIV in their blood and achieve viral suppression. Though viral suppression does not mean a person is cured, lowering the amount of virus in their body with medication can help them stay healthy, live longer and greatly reduces their chances of passing HIV onto others.

Undetectable: A person is undetectable when their viral load is under 40 copies per mL. This means there are lower amounts of HIV present in the bloodstream. According to the New York City Department of Health and Mental Hygiene (NYC DOHMH), a person living with HIV who has maintained an undetectable viral load for at least six months does not pose an HIV infection risk to their sexual partners. More information can be accessed at: <https://www1.nyc.gov/site/doh/health/health-topics/hiv-u-u.page>.

REMINDER:

- HOPWA housing provider staff must request a medical update from the consumer at each reassessment.
 - Primary care visits, emergency room visits, and hospitalizations must also be reported and documented in eCOMPAS.
 - If a consumer is non-compliant with medical appointments or not in care, program staff are required to follow up to identify the barriers and link the consumer to care.
-

QA Tips!

- Maintenance and adherence to medical care should be tracked for all consumers by the program and used to monitor treatment adherence and viral suppression outcomes.
 - Any medical documentation submitted must be dated and is only valid for up to one year.
 - If the lab results only state undetectable and do not provide a viral load count, zero should be entered via eCOMPAS.
 - CD4 counts and Viral Load are considered Public Health Information (PHI) and should not be documented in the progress notes.
-



HOPWA FACT SHEET

QUALITY ASSURANCE

Quality Assurance (QA) helps programs achieve higher standards of care through processes that improve quality of service provision, overall performance, and quality documentation practices.

The program must develop a Quality Management Plan (QMP), which defines standards, practices, resources, specifications, and activities that must be in place for the purpose of monitoring compliance with HOPWA contractual requirements and program performance.

The QMP should contain the following elements:

- Standard operating procedures to conduct routine reviews of consumer records and eCOMPAS data.
 - Sampling Method (i.e., random sampling; sample size, etc.)
 - Frequency (i.e., every month; every 3 months)
 - Staff Responsible (i.e., Program Director, Director of QA, etc.)
 - Documentation of QA Activities (i.e., QA record review tool, supervisor sign off documentation/notes), which must be available for DOHMH review
- Details regarding the Quality Assurance/Improvement Team, which would:
 - Identify roles and responsibilities
 - Determine meeting schedule
 - Formulate methodology for reviews
 - Develop a method for providing feedback to staff, senior management, and the Board, if applicable

QA activities include:

| QA Activity | Frequency | Tool |
|--|---|--|
| Review consumer charts/records to ensure all required components are present | Monthly or quarterly, at a minimum, based on the sampling method used | Consumer chart review tool |
| Review of data quality in eCOMPAS: Service entry | Monthly | Services and Productivity Report in eCOMPAS <ul style="list-style-type: none"> • Review of services, reported times, and progress notes, if applicable Monthly Program Report in eCOMPAS– Services tab <ul style="list-style-type: none"> • Review total number of services entered per service category |
| Review of data quality in eCOMPAS: Reassessments | Monthly or quarterly, at a minimum | Review each Reassessment tab in eCOMPAS |
| Review of data quality in eCOMPAS: HIMM payment entries | Monthly | Monthly Program Report in eCOMPAS – HIMM tab <ul style="list-style-type: none"> • Assignment Report • Payments Report |

| | | |
|-------------------------------|------------------------------------|---|
| | | |
| Peer Review | Monthly or quarterly, at a minimum | A review tool such as a checklist |
| Supervisory/Managerial review | Monthly, at a minimum | Supervisory Review Tool <ul style="list-style-type: none"> Identifies areas of improvement and expectations moving forward |

REMINDER:

- Documentation of QA activities can be maintained in consumer files or in a separate QA binder.
- The QMP must include review of eCOMPAS data quality.

Appropriate QA follow-up activities must be documented to ensure outstanding issues are addressed in a timely manner.



HOPWA FACT SHEET

RESIDENT RENT CALCULATOR WORKSHEET

All Supportive Permanent Housing (SPH) and Rental Assistance (REN) HOPWA housing providers are required to determine a HOPWA household's rent contribution. As per HUD, HOPWA consumers must pay as rent, including utilities, an amount which is the higher of (1) 30% of the household's monthly adjusted income; or (2) 10% of the household's monthly gross income.

Resident Rent Calculator Worksheet

The Resident Rent Calculator Worksheet calculates the consumer's annual gross household income to determine the household's contribution toward the monthly rent.

HOPWA SPH and REN housing providers are required to complete the Resident Rent Calculator Worksheet in eCOMPAS at the point of enrollment and updated annually thereafter (unless there is a substantial change in household income or size within the 12-month period).

Upon verification of consumer eligibility, including household income eligibility, a Resident Rent Calculator Worksheet must be:

- Completed in eCOMPAS for all consumers enrolled in HOPWA supportive housing or the Rental Assistance Program.
- Completed even if the consumer reports zero income or only receives Public Assistance.
 - Consumers who report zero income must complete a notarized Zero Income Affidavit at each rent calculation.
- Completed accurately by including the correct utility allowance amount according to the updated [Utility Allowance Schedule](#). A utility allowance is only applied if the consumer's utility is **not** included in the rent. An updated Utility Allowance Schedule is also available directly on the Resident Rent Calculator.
- Completed even if there is no change of income from one year to the next.

Initial Rent Calculation:

- The Initial Calculation in the Resident Rent Calculator Worksheet is available for completion upon the consumer's enrollment and will only be required once for the duration of their enrollment. Therefore, if the consumer is newly enrolled, the system will only allow for selection of the Initial Calculation.
- This calculation must be completed in order to determine the consumer/household's rent contribution. If the program needs a preliminary rent calculation before completing an initial one, please complete a free Resident Rent Calculator Worksheet at <https://www.freerentcalculator.com>.

Interim Rent Calculation:

- If there is a change in the consumer's household income or family size prior to the annual recertification date, then the program must update the Resident Rent Calculator Worksheet by completing the Interim Calculation.
- The consumer must provide the HOPWA program with updated income documentation or information regarding the new family size prior to updating the Resident Rent Calculator Worksheet.

Annual Rent Calculation:

- Per HUD's HOPWA requirements, at minimum, housing providers must conduct a recertification of household income on an annual basis.
- The consumer must provide the HOPWA housing providers with current annual income documentation prior to updating the Resident Rent Calculator Worksheet.
- The HOPWA housing provider must complete the Annual Recertification Calculation even if the consumer's household income or family size has not changed.

All Resident Rent Calculator Worksheets (Initial, Interim, and Recertification calculations) must be completed with the consumer present.

- The consumer must sign the printed version of the Resident Rent Calculator Worksheet attesting to having read and understood the information.
 - A copy of the signed Resident Rent Calculator Worksheet must be provided to the consumer and another copy must be stored in the consumer's chart.
-

REMINDER:

- Accurate and up-to-date household income documentation must be obtained in order to calculate the consumer's rent contribution in the Resident Rent Calculator Worksheet.
 - Annual recertification of Resident Rent Calculator Worksheets applies to all consumers, including those who receive Public Assistance and complete the notarized Zero Income Affidavits or Income/Self-Employment Verification form.
 - The household size on the Housing Status tab in eCOMPAS must be up to date to avoid errors in calculation.
 - When completing the Resident Rent Calculator Worksheet, ensure the total monthly rent per current lease agreement' (Question 23) is updated to reflect current lease terms in order to accurately reflect the Rent Subsidy Payment.
 - Housing providers may calculate a preliminary rent calculation to determine the consumer's rent portion using the Free Rent Calculator website: <https://www.freerentcalculator.com>
 - Housing Placement Assistance (HPA) programs are exempt from using the Resident Rent Calculator Worksheet.
-

QA Tips!

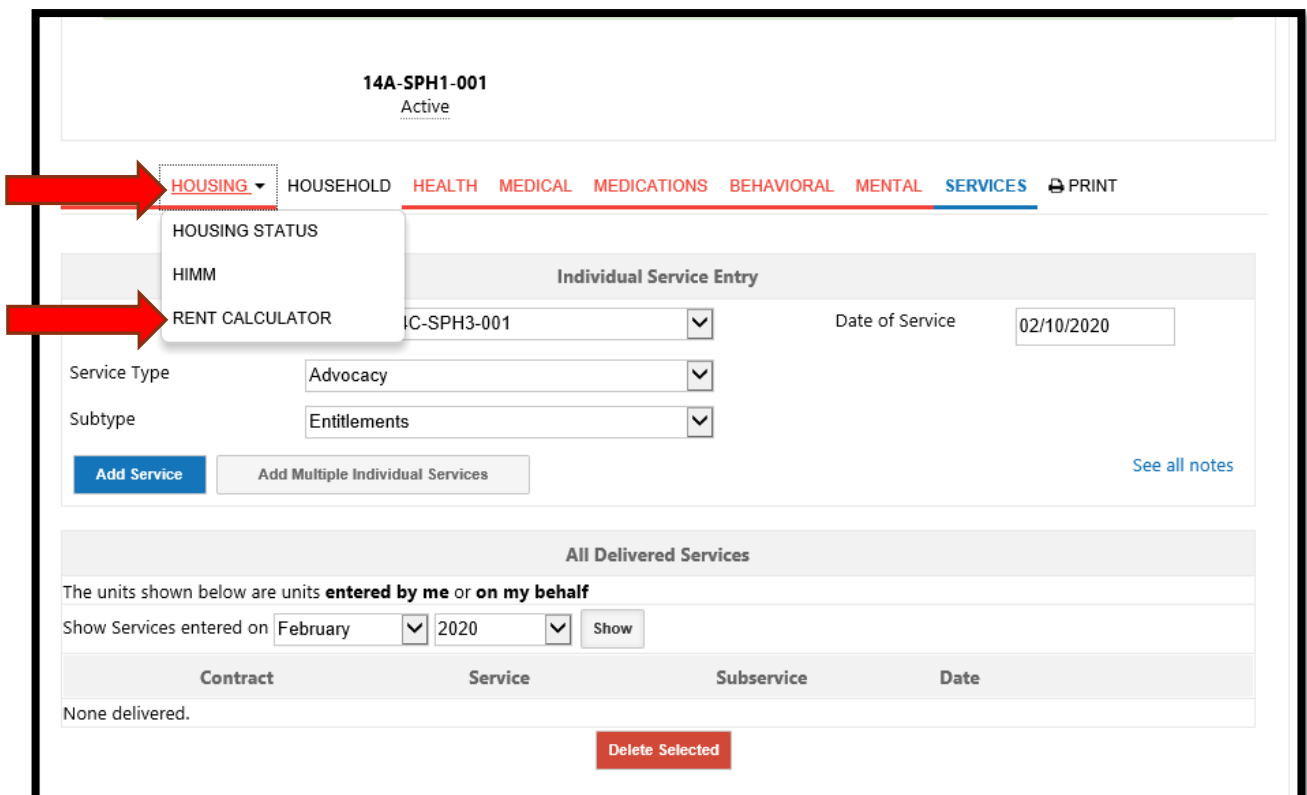
- The most current and accurate consumer rent contribution must be calculated using the Resident Rent Calculator Worksheet as the rent contribution amount must be referenced in HIMM (in the Assignments tab) as well as the Tenancy Agreement.
 - All income entered must be ANNUALIZED.
 - Income sources from all household members are required.
-

In collaboration with RDE Systems, the NYC Department of Health & Mental Hygiene’s (DOHMH) Housing Services Unit released an enhanced Resident Rent Calculator Worksheet in March 2019 with the aim of improving user experience and rent calculator accuracy for all HOPWA funded agencies.

The following is a user guide for the new Resident Rent Calculator Worksheet features with basic tips and instructions to help you navigate the form and successfully, screen for income eligibility and calculate the household’s tenant rent responsibility in accordance with the U.S. Department of Housing and Urban Development’s rules and regulations.

Accessing the Resident Rent Calculator Worksheet:

To access the updated Resident Rent Calculator Worksheet, log into eCOMPAS, click on **Main** and select the consumer. Once in the consumer’s electronic chart, click the **Housing** tab then select **Rent Calculator**.



Main Page: Once on the main page you will see a history of completed Resident Rent Calculator Worksheets. You will see details such as [Apartment ID](#), [Tenant Rent](#), [Subsidy](#) amount and the [Total Rent](#). As you complete rent worksheets, they will be listed in the main page for viewing purposes only you will not be able to edit or delete a saved worksheet.

Rent Calculator (previous version)

Resident Rent Calculator Worksheet

OVERVIEW: Any person enrolled in HOPWA funded supportive permanent housing and/or rental assistance is required to complete this rent calculator at the point of enrollment and annually thereafter (unless there is a substantial change in household income or size within the 12-month period). As per the U.S. Department of Housing and Urban Development (HUD), HOPWA consumers must pay as rent, including utilities, an amount which is the higher of (1) 30% of the household's monthly adjusted income; or (2) 10% of the household's monthly gross income.

i Please be aware that after you save a rent calculator form, you will not be able to make any edits or changes. If you need a preliminary rent calculation to determine the consumer's rent portion here, please use <https://www.freerentcalculator.com>.

+ New Calculation

| Type | Date | ApartmentID | Tenant Rent | Subsidy | Total Rent | |
|-----------------------------|------------|-------------|-------------|------------|------------|----------------------|
| Interim Calculation | 11/26/2019 | | \$350.60 | \$1,217.92 | \$1,568.52 | View |
| Recertification Calculation | 09/18/2019 | | \$0.00 | \$1,568.52 | \$1,568.52 | View |

Types of Rent Calculations:

To complete a new Resident Rent Calculator Worksheet click on **+New Calculation**. You will then be able to select from three (3) types of rent calculations.

Initial Calculation – This calculation is available upon your consumer’s enrollment and will only be required once for the duration of their enrollment. Therefore, if your consumer is newly enrolled, the system will **only allow** you to select **Initial Calculation**. **If you need a preliminary rent calculation before completing an initial one, follow the link on the Resident Rent Calculator Worksheet main page to access the [free rent calculator](#).*

GENERAL HOUSING HOUSEHOLD HEALTH MEDICAL MEDICATIONS BEHAVIORAL MENTAL SERVICES PRINT

HOUSING STATUS HIMM **RENT CALCULATOR**


[Rent Calculator \(previous version\)](#)

Resident Rent Calculator Worksheet

OVERVIEW: Any person enrolled in HOPWA funded supportive permanent housing and/or rental assistance is required to complete this rent calculator at the point of enrollment and annually thereafter (unless there is a substantial change in household income or size within the 12-month period). As per the U.S. Department of Housing and Urban Development (HUD), HOPWA consumers must pay as rent, including utilities, an amount which is the higher of (1) 30% of the household's monthly adjusted income; or (2) 10% of the household's monthly gross income.

i Please be aware that after you save a rent calculator form, you will not be able to make any edits or changes. If you need a preliminary rent calculation to determine the consumer's rent portion here, please use <https://www.freerentcalculator.com>.


+ New Calculation




GENERAL HOUSING HOUSEHOLD HEALTH MEDICAL MEDICATIONS BEHAVIORAL MENTAL SERVICES PRINT

HOUSING STATUS HIMM **RENT CALCULATOR**

Type of rent calculation REQUIRED

-  Initial Calculation (at time of program enrollment only)
- Interim Calculation prior to annual recertification (change in income or family size)
- Annual Recertification Calculation

 **Continue** Cancel

When completing calculation for a newly enrolled consumer, select **Initial Calculation** and press continue.

Once an initial calculation is completed, this option will no longer be available for future rent calculations and will be archived accordingly in the Resident Rent Calculator Worksheet homepage.

GENERAL HOUSING ▾ HOUSEHOLD HEALTH MEDICAL MEDICATIONS BEHAVIORAL MENTAL SERVICES PRINT

HOUSING STATUS HIMM RENT CALCULATOR

Type of rent calculation REQUIRED

- Initial Calculation (at time of program enrollment only)
- Interim Calculation prior to annual recertification (change in income or family size)
- Annual Recertification Calculation

Continue Cancel

Interim Calculation – This type of calculation should only be used if there has been a change in income or family size at any time prior to the regularly scheduled Annual Recertification. The system will only allow you to complete an **Interim Calculation** under these conditions.

HOUSING STATUS HIMM RENT CALCULATOR

Type of rent calculation REQUIRED

- Initial Calculation (at time of program enrollment only)
- Interim Calculation prior to annual recertification (change in income or family size)
- Annual Recertification Calculation

Type of change being reported (check all that apply) REQUIRED

- Change in household income (including entitlements and benefits)
- Change in household size or composition

Continue Cancel

Annual Recertification Calculation – This type of calculation is used on an annual basis, as HOPWA housing recipients all consumers are to be recertified at least annually. **Please note: You are required to complete an Annual Recertification Calculation even if your consumer’s income and household size HAS NOT changed.**

Rent Calculation:

Once you select a type of calculation, the rent worksheet will populate with the following information: **Calculation Date**, your consumer’s **E2ID**, **Client Apartment ID**, **Apartment Size** and **Household Size**. **If you have not assigned your consumer to a unit the **Client Apartment ID** and **Apartment Size** will be blank.*

GENERAL HOUSING HOUSEHOLD HEALTH MEDICAL MEDICATIONS BEHAVIORAL MENTAL SERVICES PRINT

HOUSING STATUS HIMM RENT CALCULATOR

| Calculation Date | E2ID | Client Apartment ID | Apartment Size | Household Size |
|------------------|-----------|---------------------|----------------|----------------|
| 02/19/2020 | ML013306H | AP03016 | 2 BR | 2 |

INSTRUCTIONS: When completing the rent calculator, include the total ANNUAL gross income of all eligible household members (e.g., payment amount multiplied by number of payment periods per year for all income sources). As per HUD regulations, agencies must obtain proof of income documentation such as pay stubs, budget letters, Social Security Income/Disability award letters, Income/Self Employment Verification (if no pay stubs are given or if self-employed), and Zero Income Affidavit* (if consumer reports no income) prior to performing the official rent calculation. Furthermore, agencies are required to maintain copies of annual income documentation in the consumer chart.

If a consumer is self-employed or reports zero income, they must complete and notarize the Income/Self Employment Verification form ([click here](#)) or the Zero Income Affidavit form ([click here](#)) and have a copy saved in the chart along with the accompanying rent calculator.

New – Please read the updated instructions for important information before completing the rent calculator worksheet.

New – For consumers that are self employed or report zero income you can access the required Income/Self Employment Verification or Zero Income Affidavit forms directly by clicking on the links in the instruction section. **If using any of these forms, make sure to fill them out and file in your consumer’s chart for record keeping.*

New – Household Size – To avoid errors in calculation, ensure that the household size for your consumer is up to date. The Resident Rent Calculator will use the household size information entered in the consumer’s assessment on the **Housing Status** tab to populate household size. **If this field is blank or has a 0, you will not be able to proceed with your calculation until this is updated.*

Resident Rent Calculator Worksheet

OVERVIEW: Any person enrolled in HOPWA funded permanent supportive housing and/or rental assistance is required to complete this rent calculator at the point of enrollment and annually thereafter (unless there is a substantial change in household income or size within the 12-month period). As per the U.S. Department of Housing and Urban Development (HUD), HOWPA consumers must pay as rent, including utilities, an amount which is the higher of (1) 30% of the household's monthly adjusted income, or (2) 10% of the household's monthly gross income.

✘ Please add the household size in the Housing Status tab before completing the rent calculator.

[+ New Calculation](#)

| Type | Date | ApartmentID | Tenant Rent | Subsidy | Total Rent | |
|-----------------------------|------------|-------------|-------------|----------|------------|----------------------|
| Recertification Calculation | 02/19/2020 | | \$841.00 | \$359.00 | \$1,200.00 | View |
| Recertification Calculation | 02/19/2020 | | \$441.00 | \$759.00 | \$1,200.00 | View |
| Initial Calculation | 02/19/2020 | | \$453.00 | \$747.00 | \$1,200.00 | View |

To resolve this validation, click on **Housing Status** tab and scroll down to the question **Total number of persons in household (including the client).**

GENERAL HOUSING HOUSEHOLD HEALTH MEDICAL MEDICATIONS BEHAVIORAL MENTAL SERVICES PRINT

HOUSING STATUS HIMM RENT CALCULATOR

Income Information

Have you received any income in the past 30 days? -- Select --

Total number of persons in household (including the client) Total number of persons in house

Gross household monthly income \$ 137.00

Currently enrolled in the HIV/AIDS Services Administration (HASA) program? -- Select --

After you save and certify this information is accurate, you can proceed to complete the resident rent calculator worksheet.

✔ Client Record Certification Form [This section was last certified 9 days ago] [History] [?]

I certify that all fields on this screen are up to date and that there is documentation on file to support the data entry on this screen.

Assessment Status - Updated - This is the latest information Certification date 03/05/2020

Update

Completing the Resident Rent Calculator Worksheet:

Step 1: Enter Annual Gross Household Income

As you complete this section, you will see that the **Annual Gross Income** and the **Monthly Gross Income** will automatically calculate as you enter the information. Please ensure that all of the income entered is **ANNUALIZED**. For instance, if you have documentation of your consumer's monthly Social Security Income, take that monthly total and multiply by 12 in order to enter the Annual Gross Income amount in the rent worksheet.


Step 1: Enter Annual Gross Household Income

1) Annual household wages and earnings (before taxes)

\$

Include the full amount (before payroll deductions) of annual wages and salaries, overtime pay, commissions, fees, tips and bonuses, and other compensation for personal services prior to payroll deductions. **ALL INCOME MUST BE ANNUALIZED.**

2) Periodic payments (social security, retirement funds, annuities, etc.)

 \$


Include periodic payments from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits, excluding lump sum payments for the delayed start of a periodic payment. **ALL INCOME MUST BE ANNUALIZED.**

3) Payments in lieu of earnings

\$

Include unemployment, disability, worker's compensation, and severance pay.

4) Alimony, child support, regular contributions or gifts received

 \$

Periodic payments received including alimony and child support, and regular contributions or gifts received from organizations or persons (including family members) not residing in the household.

5) Net income from operation of a business of profession

\$

Net income from operation of a business or profession (including but NOT limited to hairbraiding, day labor work, etc.).

6) Investments and rental income in excess of \$5,000 per year

\$

Interest, dividends, and other net income of any kind from real or personal property. Where net family assets are in excess of \$5,000, annual income shall include the greater of actual income derived from net family assets or a percentage of the value of such assets based on the current passbook savings rate, as determined by HUD.

7) Pay and allowances of a member of the armed forces

\$

Include all regular pay, special pay and allowances of a member of the Armed Forces (except Hostile Fire Pay).

8) Public assistance received

\$ 0.00

Public Assistance, including cash payments made to household members under other programs funded, separately or jointly, by federal, state, or local governments which are not excluded by Federal Statutes. Includes cash payments to household members made by the HIV/AIDS Services Administration (HASA).

9) Is the consumer/household solely dependent on Public Assistance? REQUIRED

Yes
 No

If household solely receives income from public assistance, tenant rent contribution shall equal \$0.

| | |
|---|--|
| Annual Gross Income Help | Monthly Gross Income Help |
| \$18,988.00 | \$1,582.33 |

NEW – If your consumer ONLY receives public assistance and no other income, then you should enter the amount of Public Assistance (PA) the consumer receives in line 8 and then select **Yes** to question 9, *Is the consumer/household solely dependent on Public Assistance?* Doing so will ensure the consumer’s rent contribution will be \$0.

If the consumer receives public assistance and another source of income, please enter all applicable annualized sources of income on lines 1 through 7, enter the amount of PA received in line 8 and then select **No** to question 9.

****Please remember that any answers provided in Section 1 must have valid supporting documentation.***

8) Public assistance received

\$ 4512

Public Assistance, including cash payments made to household members under other programs funded, separately or jointly, by federal, state, or local governments which are not excluded by Federal Statutes. Includes cash payments to household members made by the HIV/AIDS Services Administration (HASA).

9) Is the consumer/household solely dependent on Public Assistance? REQUIRED

Yes
 No

If household solely receives income from public assistance, tenant rent contribution shall equal \$0.

Step 2: Enter Allowances

This section includes entering the number of dependents in the household who are under the age of 18, elderly dependents, handicapped, disabled or full time students. This section also requests information on childcare and dependent expenses, as well as out of pocket medical expenses. Any applicable deductions will then automatically calculate at the bottom of Step 2.

Step 2: Enter Allowances

10) Number of dependents in the household

Dependents include household members under the age of 18, elderly dependents, handicapped, disabled, or full-time students, but not the family head of household, spouse or foster children.

11) \$400 for elderly or disabled family member

This \$400 deduction always applies to households with persons with HIV or AIDS if they are the head/co-head, spouse, or sole member, OR when the head/co-head, spouse, or sole member is at least 62 years of age. (\$400 is given one time only at each calculation and/or re-calculation of income.)

12) Reasonable childcare expenses (Annual)

These are expenses anticipated during the year for children 12 years of age or younger that enable a household member to work, seek employment, or to further their education. Deductible expenses for childcare to enable a person to work shall not exceed the amount of income received from such work. Childcare cannot be paid to another member of the household. (ONLY EXPENSES NOT REIMBURSED FROM ANY OTHER SOURCES ARE ALLOWED)

13) Attendant care expenses for non-elderly, disabled family members

This allowance covers reasonable expenses anticipated during the period for attendant care (provided by a non-household member) and/or auxiliary apparatus for any disabled household member that enables that person or any other household member to work. Deduction may not exceed the amount of income generated by the person enabled to work. (ONLY EXPENSES NOT REIMBURSED FROM ANY OTHER SOURCES ARE ALLOWED.)

14) Medical expenses and/or assistance for elderly or disabled family members

(ONLY EXPENSES NOT REIMBURSED FROM ANY OTHER SOURCES ARE ALLOWED.)

Total Non-Reimbursed Medical Expenses [Help](#)

\$150.00

3% of Annual Gross Income [Help](#)

\$0.00

Total Allowable Medical Expense Deduction [Help](#)

\$150.00

Step 3: Earned Income Disregard

The use of Earned Income Disregard (EID), which only applies to enrolled HOPWA consumers* (not newly enrolled) who obtained a job and were previously unemployed for 12 months or longer, is being considered for discontinuation by HUD. Until HUD makes a formal announcement about the fate of EID, the feature will remain on the rent calculator.

If you have included EID in your consumer's Resident Rent Calculator Worksheet, please begin the process of assessing the time remaining on each calculation and communicate to the consumer about the discontinuation of EID. **If the above scenario does not apply to your consumer, please skip this section entirely.*

Step 3: Earned Income Disregard

15) Is a member of the household receiving assistance through HOPWA, SHP, HOME, or Section 8?

Yes (All HOPWA households are eligible)
 No

16) Household earned income increased as a result of employment, after a period of unemployment of one or more years prior to employment?

Yes
 No

For local minimum wage: <https://www.dol.gov/whd/minwage/america.htm>

17) Household earned income increased as a result of participation in an economic self-sufficiency program or other job-training program?

Yes
 No

18) Household's earned income increases as a result of employment during or within six (6) months after receiving assistance, benefits, or services under TANF or a Welfare-to-Work program?

Yes
 No

This includes a one time only cash assistance of at least \$500.

19) Effective date of increase in earned income

20) Pre-Qualifying/Baseline Income

\$

Enter the total income including earned and unearned, prior to qualifying event for the EID family member.

21) Current earned (employment) income of EID family member

\$

22) Other current income of EID family member

\$

Applicable Earned Income Disregard [Help](#)

\$0.00

Step 4: Review Adjusted Income

This section is for review and information purposes only; it will show you the amounts you have entered in the previous sections. The [Help](#) link describes what is included in each section and/or how the amount is being calculated. Please be sure to carefully review the information before moving on so the rent calculator can capture all the information accurately.

The screenshot displays a financial summary with the following values:

- Annual Gross Income: \$15,000.00
- Total Allowances: \$1,360.00
- Annual Adjusted Income: \$13,640.00
- Monthly Adjusted Income: \$1,136.67

The 'Total Allowances' tooltip lists the following components:

- Number of dependents in the household multiplied by \$480.00
- \$400 for elderly or disabled family member
- Reasonable childcare expenses (Annual)
- Total Allowable Medical Expense Deduction
- Applicable Earned Income Disregard

Step 5: Tenant Rent Determination

NEW – This section requires you to enter the monthly rent amount, lease terms and utility allowance information, if applicable. You are required to answer all three questions in this section.

- If the utilities are included in the rent, be sure to answer **Yes, rent includes utilities**.
- If the utilities are not included in the rent, select **No, utilities are paid separately**, and then enter the current utility allowance. For ease of reference, you can refer to the annual approved **Utility Allowance Schedule** in the link highlighted in blue to determine the appropriate allowance for the unit.

Step 6: Results

Once all of your consumer’s information is entered, this step will provide **preliminary** results of the **Tenant Rent Responsibility** which is the consumer’s rent contribution and the **Rent Subsidy Payment**.

Please be aware: These amounts are preliminary. You must press Calculate and Save first in order to pass all system validations and obtain final results.

Step 5: Tenant Rent Determination

23) Total monthly rent per current lease agreement REQUIRED

\$ 1550

24) Current lease period (in months) REQUIRED

12

Specify the current lease period in months: e.g. 12 months, 24 months, etc.

25) Are utilities included in the rent? REQUIRED


- Yes, rent includes utilities
 No, utilities are paid separately

26) Monthly utility allowance

\$ 79.00

A tenant is only eligible for a utility allowance if utilities are NOT included in the rent charge. Copies of HUD-approved utility allowance charts may be obtained from local Housing Authorities and are updated periodically. The latest Utility Schedule can be found here: [Utility Allowance Schedule](#).

Step 6: Results

 Preliminary calculation displayed below, click "Calculate & Save Worksheet" to view final calculation.

Tenant Rent Responsibility [Help](#)

\$319.00

This is the amount the tenant pays, minus the utility allowance, if applicable. If this is a negative number, this is the amount to be reimbursed to the tenant or paid to the utility company on the tenant's behalf with their consent. The program pays the full amount of the rent (line 23) to the landlord.

Rent Subsidy Payment [Help](#)

\$1,181.00

Calculate & Save Worksheet

Cancel

Annual Income Limit Requirements: Once your Resident Rent Calculator Worksheet is calculated, the system will inform you if your consumer's income has exceeded HUD's Annual Income Limit requirements.

For Initial Calculations – If your newly enrolled consumer's income exceeds HUD's annual income limit requirements, the system will not allow you to save the worksheet deeming your consumer ineligible for HOPWA assistance.

✘ According to the information entered in the rent calculator, the household income exceeds HUD's [Annual Income Limit Requirements](#). Therefore, this household does not meet the income eligibility requirements necessary to enroll in this program.

For Annual and Interim Calculations – If your previously enrolled consumer has household income above HUD limits, the Resident Rent Calculator Worksheet will alert you that the income exceeds HUD's income requirements. If the household income is accurate, click confirm and the rent calculator will save.

Confirm Submission [X]

Annual gross household income exceeds HUD's Annual Income Limit requirements. Please review [HOPWA Income Limits](#) to determine if this household is income eligible for this program.

Please be aware that after you save this form, you will not be able to make any edits or changes. Are you sure you want to save?

Cancel Confirm

✓ Rent calculator saved successfully.

✘ Annual gross household income exceeds HUD's Annual Income Limit requirements.

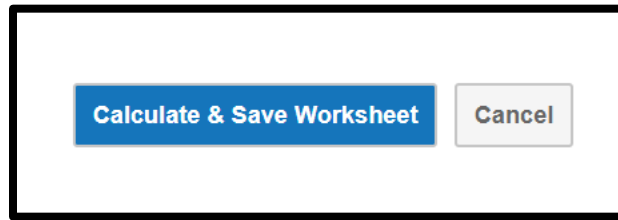
When you return to the Resident Rent Calculator Worksheet homepage, you will see the rent calculator that exceeds income limits highlighted in red to remind you to reassess your consumer's housing service plan and implement steps to graduate your consumer from the program.

[+ New Calculation](#)

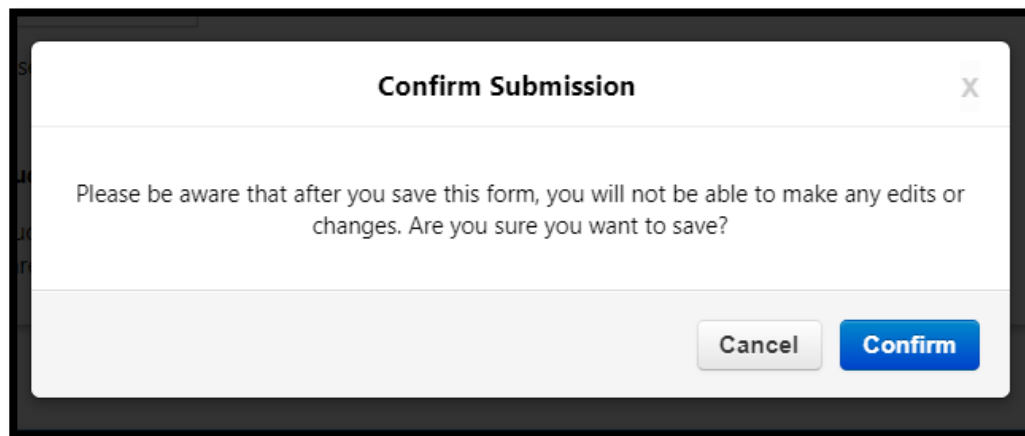
| Type | Date | ApartmentID | Tenant Rent | Subsidy | Total Rent | |
|-----------------------------|------------|-------------|-------------|----------|------------|----------------------|
| Recertification Calculation | 03/05/2020 | AP02542 | \$1,490.00 | \$35.00 | \$1,525.00 | View |
| Recertification Calculation | 01/24/2020 | AP02542 | \$350.00 | \$900.00 | \$1,250.00 | View |

Saving

NEW- To save your Resident Rent Calculator Worksheet, you must click on **Calculate and Save Worksheet**. *Remember your final results will only appear **after** your worksheet is calculated and saved. The data available in **Step 6. Results** is only preliminary data that must pass all validations after the worksheet is calculated and saved.*



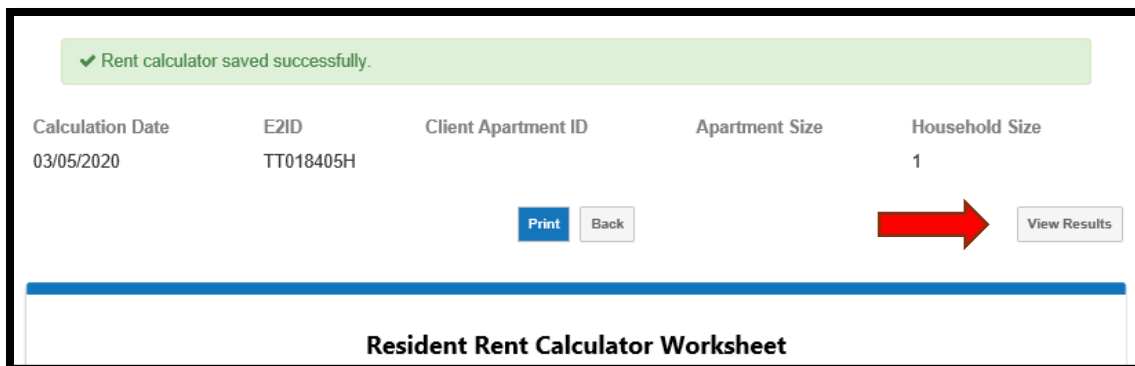
After you select **Calculate and Save Worksheet**, the system will remind you that after the form is saved you will **not** be able to make edits or changes.



Once confirmed, the Resident Rent Calculation Worksheet will be saved and immediately available for printing.

Printing:

NEW- Once saved, you should immediately **view** and **print** your completed rent calculator worksheet. Click on **View Results** to be directed to the **Tenant Rent Responsibility** and **Rent Subsidy Payment** information in the Results section.



Step 6: Results


Tenant Rent Responsibility [Help](#)

\$453.00

This is the amount the tenant pays, minus the utility allowance, if applicable. If this is a negative number, this is the amount to be reimbursed to the tenant or paid to the utility company on the tenant's behalf with their consent. The program pays the full amount of the rent (line 23) to the landlord.

Rent Subsidy Payment [Help](#)

\$747.00



Upon clicking **Print**, your print out will prepopulate the **date** and provide space for the required **Consumer** and **Staff Signature**. Once printed please complete the signatures, provide a copy to your consumer and retain a copy for the consumer's chart.

23) **Total monthly rent per current lease agreement** REQUIRED

\$1500.00

24) **Current lease period (in months)** REQUIRED

12

Specify the current lease period in months: e.g. 12 months, 24 months, etc.

25) **Are utilities included in the rent?** REQUIRED

Yes, rent includes utilities
 No, utilities are paid separately

Step 6: Results

Tenant Rent Responsibility [Help](#)

\$915.00

This is the amount the tenant pays, minus the utility allowance, if applicable. If this is a negative number, this is the amount to be reimbursed to the tenant or paid to the utility company on the tenant's behalf with their consent. The program pays the full amount of the rent (line 23) to the landlord.

Rent Subsidy Payment [Help](#)

\$585.00

Date: 02/19/2020

Consumer Signature: _____

Staff Signature: _____

Reminder: Please provide consumer with a copy of the rent calculator and file a copy in their chart along with all accompanying income documentation used to determine the calculation.

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If you need to print an older calculation you can access it from the **Resident Rent Calculator Worksheet** main page where you can view and print.

Resident Rent Calculator Worksheet

OVERVIEW: Any person enrolled in HOPWA funded permanent supportive housing and/or rental assistance is required to complete this rent calculator at the point of enrollment and annually thereafter (unless there is a substantial change in household income or size within the 12-month period). As per the U.S. Department of Housing and Urban Development (HUD), HOWPA consumers must pay as rent, including utilities, an amount which is the higher of (1) 30% of the household's monthly adjusted income; or (2) 10% of the household's monthly gross income.

i Please be aware that after you save a rent calculator form, you will not be able to make any edits or changes. If you need a preliminary rent calculation to determine the consumer's rent portion here, please use <https://www.freerentcalculator.com>.

[+ New Calculation](#)

| Type | Date | ApartmentID | Tenant Rent | Subsidy | Total Rent | |
|-----------------------------|------------|-------------|-------------|------------|------------|----------------------|
| Recertification Calculation | 02/19/2020 | | \$453.00 | \$747.00 | \$1,200.00 | View |
| Initial Calculation | 02/18/2020 | | \$302.50 | \$1,255.50 | \$1,558.00 | View |

Once on the main page, click **View** on the worksheet you would like to print, the calculator worksheet will populate allowing you to also **View Results** and **Print**:

HOUSING STATUS: [Home](#) [RENT CALCULATOR](#)

| Calculation Date | E2ID | Client Apartment ID | Apartment Size | Household Size |
|------------------|-----------|---------------------|----------------|----------------|
| 02/14/2020 | ML013306H | AP03016 | 2 BR | 2 |

[Print](#) [Back](#) [View Results](#)

Resident Rent Calculator Worksheet

Type of rent calculation REQUIRED

- Initial Calculation (at time of program enrollment only)
- Interim Calculation prior to annual recertification (change in income or family size)
- Annual Recertification Calculation

[Print](#) [Back](#)

If you have any questions or need further assistance using the new Resident Rent Calculator Worksheet, please contact your assigned Program Analyst.

Thank you!

2020 UTILITY ALLOWANCE SCHEDULE

NEW YORK CITY

Utility Allowance Rates (Effective January 1, 2020):

| Cooking Gas and Electric (all Unit Types) | | | |
|--|-----------------|----------------------|---|
| # Of Bedrooms | Gas (\$) | Electric (\$) | Total (\$) With Gas & Electric |
| 0 (Studio Unit) | \$22 | \$64 | \$86 |
| 1 | \$25 | \$72 | \$97 |
| 2 | \$28 | \$93 | \$121 |
| 3 | \$31 | \$115 | \$146 |
| 4 | \$35 | \$136 | \$171 |
| 5 or More | \$38 | \$157 | \$195 |



HOPWA FACT SHEET

HOPWA DOCUMENTATION GUIDANCE FOR SUPPORT SERVICES

HOPWA housing providers must ensure to appropriately document and track consumer service delivery using eCOMPAS.

For the purpose of accurate categorization of services, HOPWA housing providers must ensure staff are familiar with the contracted service type definitions included in the HOPWA Service Directive. This will allow housing providers to accurately report services against projected service target goals.

HOPWA service delivery **must** be entered in eCOMPAS with accompanying service notes that provide descriptive summaries of the services provided to the consumer. As a best practice, HOPWA housing providers are encouraged to enter service notes in eCOMPAS along with service delivery entries.

Individual Service Notes

Service notes are an important monitoring tool used by DOHMH to assess if:

- Programs produce results that align with HOPWA program goals.
- Services match consumers' needs.
- Programs are performing as expected.
- Programs are cost-efficient and cost-effective.
- Service time reported should include any preparation in the lead up to the service delivered and documentation time.

Documenting Service Delivery Entries

- All service delivery must be entered in eCOMPAS.
- Housing providers must ensure to categorize and report services correctly.
- Service dates in the future entered in eCOMPAS are not valid.
- The length of time for service delivery reported should include any preparation in the lead up to the service delivered and documentation time.
- Service times and dates cannot overlap.

Documenting Service Notes

Service notes must be printed and maintained in consumer charts. Service notes must include:

- The service type provided.
- The date of the service provided.
- Encounter types, such as home visits, telephone calls (if applicable), office visits, etc., which must be clearly indicated in notes (e.g., 'During the home visit...').
- A description of what took place during the encounter with the consumer and/or collateral.
- A description of follow-up plans and/or referrals, if applicable.
- Review and signature of program supervisors.

Group Service Notes

A descriptive, narrative summary of the group service note must include:

- The topics discussed.
- Appropriately categorized service.

- Group session date and length of time.

Group service notes should be filed in a group binder with the corresponding sign-in sheet for the session and attendance must be documented in consumers' Service Plan. A group session qualifies only if at least three or more HOPWA consumers attend.

REMINDER:

- Ideally, service notes should be completed in the chart and eCOMPAS within 48 hours of each service provided.
 - The HOPWA Service Directive should be referred to for guidance on categorizing service delivery.
 - Service notes should be concise, while providing a description of the service type and encounter with the consumer.
-

QA Tips!

- In addition to service notes, housing providers can also enter progress notes in eCOMPAS, which is a feature that allows for additional information to be captured for consumer service delivery. Please note that progress note entry is optional.
 - Protected Health Information (PHI) like names, addresses, viral load and CD4 counts, should not be included in service notes that are reported in eCOMPAS.
-

Examples of Service Notes:

| Service Date and Client ID | Case Manager Name and Service Encounter Time | Service Type | Narrative Description |
|----------------------------|--|---|---|
| 02/04/2020 XXXXXXXX | John Smith 12:20:00 13:15:00 | Life Skills Management Independent Living Skills - Individual | CM met consumer at home to discuss progress with opening a new bank account. Consumer reported being able to open the account. CM utilized motivational interviewing to direct the discussion to talk about the consumer paying their rental arrears and outstanding personal expenses. Consumer reported currently managing a storage locker, travel expenses and high cell phone and ConEd bills. CM provided budget counseling on how to manage household income vs. personal expenses. CM will continue to counsel the client on budgeting their income during the next session. |
| 02/19/2020 XXXXXXXX | Amy Melendez 10:00:00 10:45:00 | Counseling Supportive - Individual | The CM met with the consumer at the office and asked about their well-being. Consumer stated that they had been depressed and felt unmotivated to do anything. Consumer stated briefly contemplating "going back to the streets". CM used reflective listening skills and validated consumer's concerns and emotions. CM stated wanting to refer consumer to additional supportive services and resources to address current needs and disposition. CM will provide referral information in the next 2 days. Consumer presented to be distraught. Eye contact was good. Grooming and hygiene good. Speech normal. |
| 03/01/2020 XXXXXXXX | John Smtih 11:00:00 11:20:00 | Advocacy - Housing | CM received a call from the consumer stating that they had just arrived home and therefore, would like to reschedule delivery of a refrigerator by the maintenance department. The CM on behalf of the consumer called and emailed the liaison in the agency's maintenance department to arrange a new delivery date for the refrigerator. The CM will follow up with the consumer to ensure that a new date is scheduled, and the consumer will be present for the delivery. |

HOPWA Service Directive

The Service Directive provides Housing Opportunities for Persons with AIDS (HOPWA) program staff with guidance on appropriate categorization of HOPWA contracted services. The Service Directive contains all contracted service types with their corresponding definitions as well as non-exhaustive lists of examples to be used for contract reporting purposes in chart documentation and eCOMPAS accordingly.

HOPWA services must be reported in eCOMPAS with accompanying progress notes in the consumer chart. Services should be based upon the consumers' individualized service plan and information collected during the Assessment/Reassessment. All services must be conducted face-to-face, apart from some Advocacy encounters, or unless there are extenuating circumstances which require prior approval from DOHMH.

| Service Type | Definition | Examples |
|---|--|---|
| <p style="text-align: center;">Advocacy – Entitlements</p> | <p>Support a consumer to obtain and maintain access to benefits or entitlements.</p> <p>These entitlements may include but are not limited to:</p> <ul style="list-style-type: none"> - HIV/AIDS Services Administration (HASA) - Public Assistance (PA) - Supplemental Security Income (SSI) - Social Security Disability Income (SSDI) | <ul style="list-style-type: none"> • Assisting a consumer prepare and gather eligibility documentation. • Contacting case workers regarding eligibility and/or existing benefits or entitlements. • Assisting a consumer with recertification processes. • Requesting documentation for benefits or entitlements verification. |
| <p style="text-align: center;">Advocacy – Health Care</p> | <p>Support a consumer to obtain, schedule or maintain health care services.</p> <p>These health care services may include but are not limited to:</p> <ul style="list-style-type: none"> - Medical - Dental - Home Health Care - Mental Health | <ul style="list-style-type: none"> • Connecting a consumer to a health care provider, including but not limited to those described in the Definition list. • Requesting documentation on behalf of a consumer such as lab results or medical provider note from a health care provider. • Assisting a consumer schedule an appointment with health care providers. |

HOPWA Service Directive

| | | |
|---------------------------|---|--|
| | <ul style="list-style-type: none"> - Nutrition - Substance Use/Treatment Adherence | |
| Advocacy – Housing | <p>Assist a consumer with housing, housing stability and housing-related services.</p> | <ul style="list-style-type: none"> • Working with landlords/real estate brokers/management companies to obtain housing units on behalf of HOPWA consumers. • Negotiating leases with landlords to ensure rents do not exceed HUD’s annual Fair Market Rent (FMR) guidelines. • Requesting housing repair issue(s) on behalf of a consumer. • Inspecting a potential apartment for suitability on behalf of consumer prior to consumer viewing unit. |
| Advocacy – Other | <p>Assist a consumer obtain and/or maintain services other than those related to entitlements, health care, and housing.</p> <p>Additional activities include:</p> <ul style="list-style-type: none"> - Complete apartment inspections (SPH & HPA only) and online reviews of building and apartment violations. - Conduct follow up on outstanding issues to service providers, landlords, difficult to engage consumers, etc. <p><i>A limited number of follow up services should be reported and not be the majority of the total amount of Advocacy services reported for the month.</i></p> <p><i><u>Please note:</u> Scheduling or reminders about home visits, escort appointments, CAB meetings, etc cannot be reported as Advocacy-Other or another type of service.</i></p> | <ul style="list-style-type: none"> • Assisting a consumer obtain or maintain services such as access-a-ride, job training, food pantry, legal services, childcare, etc. • Conducting housing inspections and online reviews of apartments and buildings including: <ul style="list-style-type: none"> - Completing an inspection of an apartment to ensure the unit and the building are habitable, safe and satisfactory per HOPWA Housing Quality Standards (HQS) requirements. - Conducting online reviews of apartment and building violations prior to placing a consumer in a unit using the following online databases: Department of Buildings (DOB), Housing Preservation & Development (HPD) and Environmental Control Board (ECB). • Follow up encounters include: <ul style="list-style-type: none"> - Reaching out to difficult to engage or challenging consumers about appointments (e.g. home visits, medical appointments, etc.), lab results, case conferences, and program requirements (e.g. reassessments and service plan completion). |

HOPWA Service Directive

| | | |
|--------------------------------|--|---|
| | | <ul style="list-style-type: none"> - Reaching out to a health care provider on behalf of a consumer regarding outstanding medical or lab documentation. - Following up with a landlord on behalf of the consumer to assess status of a previously requested and outstanding repair issue. |
| Apartment Inspections | <p>Perform apartment inspections to assess the habitability of a housing unit and verify consumer occupancy. Staff should ensure housing units meet federal, state, and local Housing Quality Standards (HQS). Program staff must perform an initial housing inspection at the point of consumer program enrollment and an annual inspection, thereafter.</p> <p><i>Reportable service for Rental Assistance Program only.</i></p> | <ul style="list-style-type: none"> • Conducting an inspection of a housing unit to ensure all rooms in the unit as well as building common areas are habitable, safe and satisfy federal, state and local HQS standards. |
| Assessment/Reassessment | <p>Perform a complete evaluation of the consumer's overall health and well-being. The assessment is the initial evaluation at the point of enrollment and the reassessment builds on what was captured in the original assessment.</p> <p>Topics include:</p> <ul style="list-style-type: none"> - General Demographics and changes - Healthcare status - Housing Status - Financial resources and changes - Mental health - Substance use - Education/Employment - Support systems (e.g. family, friends) | <ul style="list-style-type: none"> • Documenting changes to the consumers' household size, income, and employment status. • Assessing a consumer's need for mental health, including behavioral health, and substance use services. • Assessing and documenting a consumer's linkage to primary care, adherence to medication, viral suppression, and hospitalizations. • Assessing a consumer's unmet needs, such as food and nutrition or employment training, in order to provide suitable referrals |

HOPWA Service Directive

| | | |
|--|---|---|
| | <p><i>Initial Assessments must be completed within 30 days of program enrollment. A Reassessment must be completed every 90 days, thereafter.</i></p> | |
| <p>Escorts – Entitlements and Housing</p> | <p>Accompany a consumer to an off-site appointment related to entitlements (i.e., PA; SSI/SSDI; HASA; etc.) or housing. The purpose of accompanying a consumer is to ensure compliance with the appointment, provide advocacy, and/or ensure transport services.</p> <p><i>Escort times entered in eCOMPAS cannot exceed 4 hours.</i></p> | <ul style="list-style-type: none"> • Accompanying a consumer to apply or recertify for benefits and/or entitlements. • Accompanying a consumer to appeal the denial of benefits and/or entitlements. • Accompanying the consumer to view potential apartments. |
| <p>Escorts – Health Care</p> | <p>Accompany a consumer to an off-site appointment related to health care services. The purpose of accompanying the consumer is to ensure compliance with the appointment, provide advocacy, and/or ensure transport services.</p> <p><i>Escort times entered in eCOMPAS cannot exceed 4 hours.</i></p> | <ul style="list-style-type: none"> • Accompanying a consumer to an off-site appointment such as a primary care provider or specialist (i.e., internal medicine, OB/GYN, cardiologist; pulmonary; etc.); substance use treatment program; psychotherapist; etc. |
| <p>Health Promotion and Education (Individual or Group)</p> | <p>Provide educational and informational sessions on health-related topics to consumers. Counseling is conducted in order to equip consumers with knowledge and skills to make informed decisions about their health and well-being.</p> | <ul style="list-style-type: none"> • Conducting education and counseling sessions regarding: <ul style="list-style-type: none"> - General health and nutrition. - Adherence to HIV medication. - Strategies to achieve and maintain viral suppression. - Benefits for getting into and remaining in care. • Conducting education and counseling sessions on tools/strategies to: <ul style="list-style-type: none"> - Improve provider and patient relationships. - Reduce risky behaviors. |

HOPWA Service Directive

| | | |
|--|---|---|
| | <p><i>Individual or Group services can be provided. Group sessions must include at least three or more HOPWA consumers.</i></p> | <p><i>Please note: Reminders to take medications and attend appointments are not considered a Health Promotion and Education service.</i></p> |
| <p>Housing Readiness Workshop (Group)</p> | <p>Provide group presentations to consumers to increase their knowledge and awareness of strategies they can employ to obtain and/or maintain supportive and independent housing.</p> <p><i>Group presentations must include at least three or more HOPWA consumers.</i></p> | <ul style="list-style-type: none"> • Presentation topics to consumers may include: <ul style="list-style-type: none"> - Understanding of housing options (e.g., congregate, scatter-site, permanent, transitional, independent, Section 8, Senior Housing). - Searching for a unit. - Understanding lease terms and tenant rights. - Building and maintaining solid relationships with realtors and brokers. - Completing housing applications. - Developing effective communication and financial management skills. |
| <p>Independent Living Skills</p> | <p>Deliver skills building counseling sessions to consumers to maximize their independence and strengthen their coping and self-advocacy skills. To best support individual needs, a comprehensive assessment of the consumer should be conducted first to identify, strengths and weaknesses in performing activities of daily living (ADL).</p> | <ul style="list-style-type: none"> • Conduct counseling sessions related to: <ul style="list-style-type: none"> - Medication management. - Task completion. - Communication and interpersonal skills. - Transportation skills. - Reduction/elimination of disruptive behaviors. - Problem solving skills. - Money management skills and living within a budget. - Vocational skills. - Household maintenance skills (e.g., grocery shopping, housekeeping). • Conduct counseling and information sessions on maintaining program compliance with a focus on HOPWA program policies and requirements, including annual recertifications (e.g., Resident Rent Calculator Worksheets, income documentation, Subleases, HIPAA/consents, HQS inspections, etc.). |

HOPWA Service Directive

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| <p>Mental Health Counseling (Group and Individual)</p> | <p>Provide psychotherapy to a consumer diagnosed with mental illness disorder(s).</p> <p><i>Individual or Group services can be provided. Group sessions must include at least three or more HOPWA consumers.</i></p> <p><i>The provision of mental health counseling is limited to a licensed psychiatrist; licensed psychologist (i.e., Ph.D., Psy.D.); licensed mental health counselor (LMHC); licensed clinical social worker (LCSW); master in counseling and/or psychology under the supervision of a licensed LMHC or licensed psychologist; or a licensed master social worker (LMSW) under the supervision of a LCSW, licensed psychologist or psychiatrist.</i></p> <p><i>All service providers must be licensed by the New York State Education Department – Office of the Professions in one of the above-referenced professions. A psychiatrist must also be Board-certified in psychiatry by The American Board of Psychiatry and Neurology. Refer to Program Policy Guidance 2014_01 Mental Health Counseling Services for additional information concerning group composition and reporting.</i></p> | <ul style="list-style-type: none"> • Evaluating the mental health needs of consumer with history of mental health diagnosis and developing goals, plans, and connecting consumer to resources. • Completing a psychosocial assessment. • Assessing consumer’s barriers to mental health treatment and treatment adherence. • Assisting a consumer in a mental health crisis and ensuring the consumer receives the appropriate follow up treatment. • Implementing and examining status of assessment-based treatment plans. |
| <p>Referral</p> | <p>Assist consumers identify and contact a resource/service provider that can address an unmet need or problem.</p> | <ul style="list-style-type: none"> • Contacting social service providers (i.e. legal services, food pantry services, substance use services, etc.) to gather information for the consumer; schedule an appointment for the consumer; and follow up on the referral. |

HOPWA Service Directive

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| | <p><i>A referral should include an appointment or related linkage activity scheduled for a service provider/resource.</i></p> | <ul style="list-style-type: none"> • Documenting and following up with the consumer and/or service provider about the outcome of the referral and whether needs have been addressed. |
| <p>Service Plan Development/Update</p> | <p>Identification, development, and update of long-term and short-term goals and the action steps (including timeframes) necessary to achieve these goals. Service Plans should be developed collaboratively between the consumer and staff and be based upon needs identified in the Assessment/Reassessment.</p> <p><i>Service Plans should be developed within 30 days of program enrollment and every 90 days thereafter.</i></p> <p><i>All Service Plans must contain a housing and a medical goal.</i></p> | <p>Service Plan goals may include:</p> <ul style="list-style-type: none"> • Attend all primary care appointments. • Attend group substance use counseling sessions on a bi-weekly basis. • Adhere to medication regimen in order to reach viral suppression within the 3 months. • Consumer to make themselves available during forthcoming home visits. • Search for employment opportunities. • Enroll in college courses before the start of the school semester. |
| <p>Substance Use Counseling (Group and Individual)</p> | <p>Provide counseling to consumers to address issues related to the dependence and/or misuse of alcohol, tobacco, and other drugs. This includes but is not limited to using a harm reduction approach for reducing the harm associated with the use of alcohol, tobacco, and other drugs.</p> <p><i>The provision of substance use counseling is limited to a credentialed individual such as a Credentialed Alcoholism and Substance Abuse Counselor (CASAC). Refer to Program Policy Guidance 2009_004 Group Services for additional</i></p> | <p>Deliver Substance Use Counseling sessions, including but not limited to:</p> <ul style="list-style-type: none"> • Providing counseling to address a consumer’s barrier(s) to sobriety. • Assisting a consumer in a crisis and ensuring the consumer receives the appropriate follow up treatment. • Completing a psychosocial assessment. • Implementing and reviewing status of assessment-based treatment plans. |

HOPWA Service Directive

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| | <p><i>information concerning group composition and reporting.</i></p> <p><i>Note: Sobriety/clean time is not a prerequisite for program enrollment or a program requirement, nor can consumers be terminated from the program if they engage in substance use.</i></p> <p><i>Individual or Group services can be provided. Group sessions must include at least three or more HOPWA consumers.</i></p> | |
| <p>Supportive Counseling (Individual or Group)</p> | <p>A cooperative process between the program staff and consumer to identify sources of difficulties or concerns that the consumer is experiencing. Together, the staff person and consumer develop ways to address issues, so the consumer has new skills and increased understanding of themselves and others.</p> <p><i>Supportive counseling excludes mental health, and substance use counseling; it should not be provided in lieu of mental health and/or substance use counseling for persons diagnosed with a mental health disorder(s). However, supportive counseling may be provided in concert with mental health and substance use services, when necessary.</i></p> <p><i>Individual or Group services can be provided. Group sessions must include at least three or more HOPWA consumers.</i></p> | <p>Counseling encounters may be related to:</p> <ul style="list-style-type: none"> • Provision of support for relationship issues, family problems, grief, health issues, housing and/or employment instability, etc. • Discussions around reducing risky behaviors, developing coping strategies, etc. • Treatment adherence support to achieve viral suppression. |
| <p>Unsuccessful Follow-Up</p> | <p>Unsuccessful attempts by staff to:</p> <ul style="list-style-type: none"> - Establish contact and reach consumers | <p>Unsuccessful attempts that can be reported as a service include:</p> |

HOPWA Service Directive

- Outreach to consumer’s providers (e.g. medical, social service, landlord, etc.)
- Provide escort services

In cases where staff travels to the consumer’s home (i.e., home visit), the agency can report the travel time to/from the consumer’s home and the office. The same is also true for escort attempts (i.e., Escorts – Entitlements and Housing and Escorts – Healthcare).

Unless home visits or escorts, multiple attempts made by the program by telephone for a single consumer (or service provider, landlord) for a particular event can only be reported once during a given month. Along with the single reported service, the multiple attempts for that particular event should be summarized in one progress note.

- Attempt to conduct a home visit, however, the consumer is not home, denies entry or unable to see staff.
- Consumer is a no-show for an escort service to a medical and/or entitlement appointment, service provider, or apartment viewing.
- Attempt to leave a voicemail message for a consumer but unable to do so (i.e., phone is no longer in service; attempt to call consumer but consumer does not answer, or consumer’s voicemail service is not working/not set up). *This service can only be reported once during a given month for a single consumer for a particular event.*
If able to leave a voicemail message, then the service would be reported as Advocacy-Other.
- Attempt to leave a voicemail message for a service provider but unable to do so (i.e. phone no longer in service, voicemail is not working/not set up, etc.) *This service can only be reported once during a given month for a single consumer for a particular event.*
If able to leave a voicemail message, then the service would be reported as Advocacy-Other.



HOPWA FACT SHEET

SERVICE PLAN DEVELOPMENT/UPDATES

Service Plan Development & Updates include identification, development, and update of long-term and short-term goals and the time specific action steps necessary to achieve these goals. Service Plans should be developed collaboratively between the consumer and staff and be based upon needs identified in the Assessment/Reassessment. Service Plan goals should be specific, measurable, achievable, realistic, and time bound (S.M.A.R.T.).

The initial service plan development, upon intake, must be completed within 30 days of enrollment. Service plan updates take place every 90 days afterwards.

- Service plans **must** be completed in conjunction with an assessment/reassessment.
- Service Plan Goals should address needs identified during the assessment/reassessment.
- When completing a service plan any issues affecting the consumer's housing stability must be addressed.
- A housing, a medical, and an independent living specific goal must be included in each service plan (i.e. one of each is required at minimum, see Service Plan Template as a sample).
- If an issue requires a referral, the referral outcome must be included in the service plan update whether or not the goal is met.
- If a service plan goal is not met by the time the next service plan update is due, a goal to address the barrier(s) should be present in the following service plan update.
- When documenting the service plan encounter in eCOMPAS, the time reported should include any preparation in the lead up to the service delivered, the actual service plan development session with the consumer, and documentation time. The expected length of time for HOPWA staff to develop, conduct, and document a service plan is at minimum one hour.

REMINDER:

- A comprehensive service plan includes long-term and short-term goals that are specific to the needs of the consumer.
- Service plans should evolve over time, they should not mirror each other every 90 days.
- Service plan goals should be realistic and consider the consumer's current situation.
- If extenuating circumstances (e.g. illness, medical appts) prevent the completion of a service plan during the assessment/reassessment, the start date of the initial assessment/ reassessment should be used to enter the service in eCOMPAS.
- If a consumer is unavailable to complete a service plan when it is due, the reason must be documented in the service notes and the service plan must be completed as soon as possible. The following scheduled service plan should take place as scheduled and not delayed due to the delayed completion of the service plan.

QA Tips!

- HOPWA housing program staff and consumer must sign and date each service plan.
- Ensure that the service plan aligns with the needs identified at each assessment/reassessment.
- Service plans are designed to help consumers achieve housing stability, quality health outcomes such as viral suppression, and independent living skills.

LEGAL GOALS (IF APPLICABLE)

LT GOAL: _____ DATE Achieved: _____

ST GOAL: _____ DATE Achieved: _____

LT GOAL: _____ DATE Achieved: _____

ST GOAL: _____ DATE Achieved: _____

| Action Steps | Persons responsible | Target Date | Completion Date |
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Client's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____



HOPWA FACT SHEET

TERMINATION AND GRIEVANCE

HOPWA regulations require housing providers to develop grievance and termination policies in order to protect the rights of and provide due process for HOPWA consumers.

Upon enrollment in the program:

- The consumer must be provided with written copies of the termination and grievance policies and should be reassessed annually.
- The termination and grievance policies must include a section for consumer signature and date for acknowledgement of receipt and understanding of policy. Housing provider staff must also sign and date the policies.
- Signed copies of the policies must be provided to the consumer and originals must be kept in the consumer record.
- Program staff must explain that consumers who repeatedly and/or seriously violate program rules or conditions may be terminated from the program.

Termination

Termination of assistance occurs when a consumer is no longer eligible for HOPWA-funded housing assistance. The HOPWA housing provider may only terminate assistance in limited circumstances as prescribed by HUD regulations and program requirements set forth by DOHMH. *HOPWA housing providers are required to counsel consumers to address compliance issues, if any, and implement corrective action measures outlined in service plans prior to attempting to terminate a consumer's housing assistance.*

HOPWA regulations require a formal process for handling the termination of HOPWA consumers. As such, all housing providers should design and implement a termination policy in accordance with the guidance below.

HOPWA termination procedures should address termination due to one of the following:

- Death of the consumer
- Criminal activity
 - In severe cases (e.g. violence, serious threats of violence toward staff or other consumers), discharge from the program must be immediate.
- Violation of regulations/program requirements/conditions of occupancy
- Absence from unit for over 90 days

The program must document reasonable efforts and interventions that demonstrate attempts to encourage consumers' compliance with program rules and expectations.

When termination is necessary:

- The participant must be provided notice, in writing that clearly states the reason for termination.
- The consumer must be given the opportunity to dispute or appeal the termination.
- Notice of the final decision must be provided to the consumer in a timely manner.
- The termination process must be properly documented, and all documentation must be maintained in the consumer record.

The following information must be captured during the termination process and maintained in the consumer's file:

- Written notice(s) of termination addressed to the consumer
- Service notes regarding consumer encounters (or attempts at encounters) leading to consumer termination
- Alternate housing options for consumers
- Case Conference notes, signatures and dates
- Referral documentation
- Termination summary documentation in the consumer's record containing relevant information including, but not limited to:
 - Termination date
 - Reason for termination
 - Outcome of termination
 - Referrals
 - Summary of services
 - Appropriate signatures/dates
 - Discharge follow-up plan (if applicable), etc.

Grievance

HOPWA housing providers are required to develop and implement a grievance policy, which outlines the process for consumers to bring forth complaints or raise concerns related to denial of services or services received without fear of retribution.

Consumers are entitled to the grievance being handled in an expedient, confidential, sensitive and non-judgmental manner.

- Formal grievances made by consumers must be in writing or telephone and must be directed to the appropriate HOPWA housing provider supervisor.
- The grievance policy must outline who will review and act on grievances (as in the chain of decision-making power)
- Consumers not satisfied with the outcome offered by the housing provider can file a grievance with DOHMH.
 - Consumers should first exhaust the grievance procedures offered by the HOPWA housing provider. If consumers want to proceed with filing a grievance with DOHMH, the appropriate DOHMH contact (Housing Services Unit Director name, telephone number, address) must be provided.
- A detailed description of the nature of the grievance being reported must be captured by HOPWA housing provider staff, including dates, names of individuals involved (e.g., consumer, staff)
- Documentation of previous complaint(s) filed must be provided, if applicable.
 - Summary of outcome of previous complaint(s) filed and resolution(s), if any. Include corresponding written documentation, if applicable.
- All grievance documentation must be maintained in the consumer chart.

REMINDER:

- The discharge process must be consistent with the housing providers termination policy and DOHMH and HUD guidelines.
- Housing provider staff must make every effort to make sure consumers are able to access alternate housing prior to consumer termination.
- If possible, consumers must sign and date termination documentation prior to consumer disengagement from the program.

QA Tips!

- Upon consumer discharge, ensure to categorize the closure accurately in eCOMPAS under Enrollment Status.
 - If the Enrollment Status is Closed - Other, provide a brief description of the discharge reason in Case Closure Notes.
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