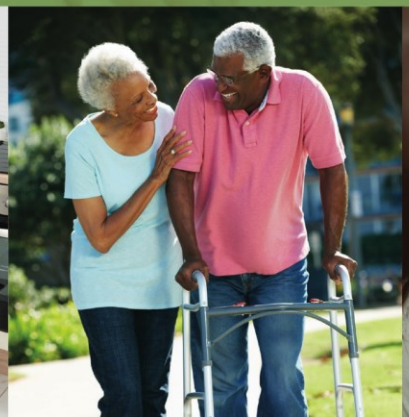
NEW YORK ASSOCIATION ON INDEPENDENT LIVING

Olmstead Housing Subsidy Program

A program that works for both tenants and landlords!

Introduction to NYAIL

- New York Association on Independent Living
  - Statewide, not-for-profit membership association of Independent Living Centers.
  - ILCs are unique disability-led, cross-disability, locally administered not-for-profit organizations, providing advocacy and supports to assist people with disabilities of all ages to live independently and fully integrated in their communities.
  - ILCs have been transitioning and diverting people from institutions for more than 20 years.

NYAIL Programs

NYAIL administers several statewide programs in collaboration with its member ILCs:

- Olmstead Housing Subsidy (OHS)
  - Statewide rental subsidy and transitional housing support service program for high-need Medicaid beneficiaries.
- Rapid Transition Housing Program (RTHP)
  - Statewide rental subsidy program for high-need Medicaid Beneficiaries
- Open Doors (Money Follows People, MFP)
  - Transition Center - Transition specialists at ILCs across the state to directly assist people in nursing homes access the services they need to return to the community.
  - Peer Outreach and Referral - Peer advocates empowering people with disabilities and the elderly to take charge and make informed decisions about their lives.

Independent Living Centers (ILCs)

- ILCs are local community-based organizations run by and for people with disabilities
- The staff match the characteristics of the community (all ages, levels of ability, ethnicity)
- Started as part of the civil rights movements
- Non-residential

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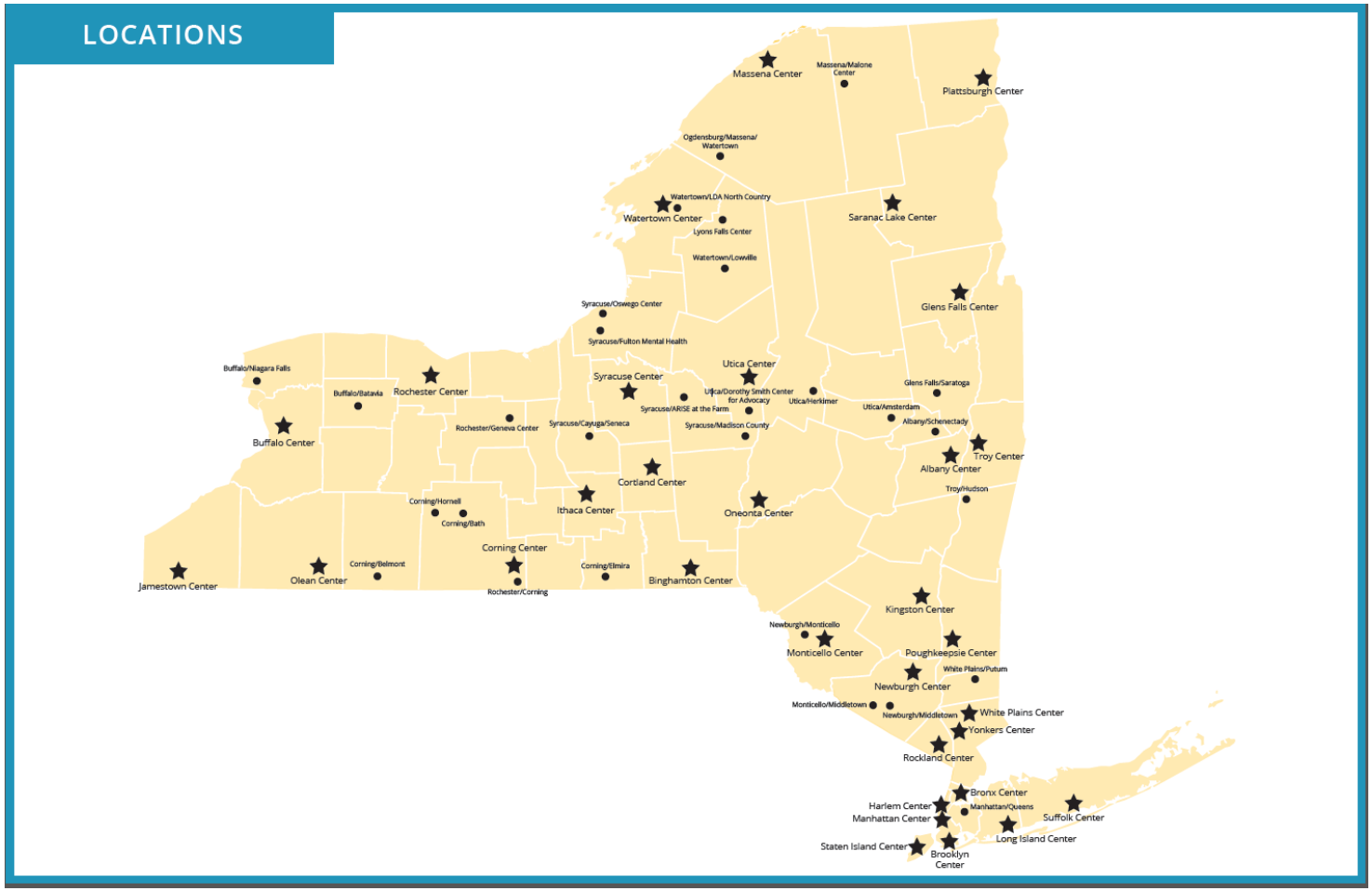
ILCs in NYS



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ILC Core Services

- All ILCs provide five core services:
  - Peer mentoring
  - Independent Living Skills Training
  - Information & Referral
  - Individual & Systems Advocacy
  - Transition

Your Local Independent Living Center

- In addition to the 5 core services, each ILC offers a variety of programs based on need. Some of which are:
  - **Open Doors Transition Specialists/Transition Services**
  - **OHS/RTH Housing Specialists/ Housing Assistance**
  - **Benefits advisors**
  - **Loan Closets/TRAID Centers**
  - **Education**
  - **NY Connects**
  - **Long Term Care Ombudsman Program (LTCOP)**
  - **Consumer Directed Personal Assistance (CDPA) Fiscal Intermediary**

Your Local Independent Living Center

- Wellness/self-management groups (e.g., chronic disease self-management, diabetes prevention program, healthy ideas)
- Barrier Consultation (e.g., assessment for ramps/accessibility)
- Food Pantries
- Affordable/accessible housing search assistance
- Representative Payee
- American Sign Language (ASL) services, specialists, advocacy
- NHTD/TBI Waiver Regional Resource Direction Centers

Link to the Independent Living Centers websites in NYS:
https://ilny.us/membership/nyail-member-ilcs

Olmstead Housing Subsidy

- Olmstead refers to the Supreme Court's 1999 Olmstead Decision, which established that people with disabilities have the right to live and receive services in the most integrated setting appropriate to their needs.
- OHS is funded by the New York State Department of Health as a program of the NYS Medicaid Redesign Team (MRT). NYAIL is administrating the grant.

Olmstead Housing Subsidy (OHS)

- The Olmstead Housing Subsidy program seeks to support those nursing home residents who can safely live in the community by assisting with the cost of rent, and by providing assistance with locating and obtaining housing. OHS is designed to mirror Section 8 Housing Choice Voucher programs.
- Rental subsidy is intended to help seniors and people with disabilities leaving nursing homes

OHS Structure

- 9 Regional Lead ILCs/ 15 Auxiliary ILCs
  - Regional Leads assign referrals to auxiliary ILCs
- 35 Housing Specialists statewide
- RCIL Fiscal Intermediary
- NYAIL Staff-
  - Director of Housing Programs
  - NYC Transition and Housing Coordinator
  - Statewide Housing Specialist Liaison (2)
  - OHS Housing Specialist

OHS Referrals Can Come From:

- Transition Specialist
- Peers
- Family
- Nursing Home staff
- NHTD/TBI
- Self- Referral
- Referral forms on our website at www.ilny.org

How does OHS Work?

- Referrals are processed at each independent living center and assigned to a housing specialist in that region.
- Intakes are set up and completed with the participant (family member/guardian/SW)
- Housing Specialist works to gather documents to determine eligibility.
- Once eligible, Housing specialist and participant work together to locate a unit, plan for CTS, work towards discharge with all stakeholders
  - Discharges from NH: If participant receives no current benefits, the program will pay full rent up to FMR for 90 days.
  - HS will notify the OHS email that a participant has moved in to their unit
  - HS will work with participant to obtain their income/benefits and notify and complete a new rental calculation
- Housing specialist and participant maintain contact while participant is receiving the subsidy.
  - Including verification of rent prior to the 15th of each month

OHS Housing Specialist Role

- Complete intake
- Collect forms from documentation checklist
- Determine eligibility
- Locate and secure unit, complete inspection
  - Units to be located are to be within FMR (Fair Market Rent) for the area they are moving to.
- Provide needed items (security, 1st month rent, Community Transition Service dollars as a last resort)
- Maintain monthly contact
- Annual unit inspection
- NOTES NOTES NOTES NOTES

OHS Housing Specialist Role

- Participant in discharge meetings
- Assist with solving barriers
- Linkages within the community for services
- Provide outreach for the program (monthly)
  - Landlords
  - Skilled Nursing Facilities
- Maintain the database
- Resource for landlords

OHS Housing Specialist Role

- Apply for or renew official identification cards
- Apply for public benefits
- Attend nursing home discharge planning meetings
- Develop a plan for community care, working with the participant's family, friends, social workers, or medical professionals
- Obtain assistive technology or durable medical equipment (not to be purchased with OHS funds)
- Schedule initial appointments with medical providers, substance abuse treatment, or mental health providers
- Establish bank accounts
- Select a pharmacy
- Identify accessible methods of transportation
- Plan for meeting food needs (not to be purchased with OHS funds)
- Orient to a new community, including bus lines, nearby stores, and community resources
- File an address change notification with the U.S. Post Office

OHS Housing Specialist Role Sustaining Services (after discharge)

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations
- Educating on the role, rights, and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords and property managers with a goal of fostering successful tenancy
- Assisting in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action
- Advocating on the tenant's behalf and linking the participant to community resources to prevent eviction when housing is, or may potentially become, jeopardized

Referral Process

- HS receives referral and makes outreach within 10 business days
- HS meets/speaks with participant, obtains consent for ROI and the program, builds rapport through intake form
- HS works with SW/participant to gather all needed documentation to determine eligibility.
- Referral process can take time due to cooperation of many people involved
- HS ensures the participant meets all eligibility before sending for review
- Follows Documentation Checklist for all eligibility and sends to Regional Lead for review
- After review, it is sent to NYAIL for final determination of eligibility

Determining OHS Eligibility

- 120- consecutive days in a nursing home (skilled nursing facility) in the most recent 24 months.
  - Hospitals, prison/jail, rehab, psychiatric institutions do not count for the 120 days
- Medicaid Eligible
- Homeless living in a Skilled Nursing facility
- 18 and older with a documented chronic disability OR 55 and older
- Income is at or below HUD FY Extremely Low Income

OHS: Information Needed to Determine Eligibility

- Referral form
- Participant consent and ROI
- Proof of identity and age
- Verification of current Medicaid Enrollment
- Income documentation
- Verification participants name was run through state and federal sex offender registries
- Verification participants name was run through NYS Inmate Population Information Search

Nursing home discharge plan/letter written and signed by social worker/MD

- Evidence participant may be safely served in the community/letter written and signed by social worker/MD
- If under age 55, verification of chronic disability
  - A doctor's letter/ proof of participants receipt of SSDI

OHS Housing Subsidy Unit Information

- Unit must be Fair Market Rate
- Individual required to pay 30% of their income and utilities (if not included)
- Supply required documentation
- Sign annual lease with landlord
- Sign OHS participant agreement
- Participant to maintain monthly contact with HS
- Apply for and accept Section 8 when available

Community Transition Service Dollars: (CTS)

- $5000 limit per participant
- Security deposit
- Household items
- Household Furnishings
- Utility deposit
- Small E-Mods
- Mover’s fees

One-Time Assistance: (CTS)

- For participants who are working with Housing Specialists to locate units, and find subsidized housing:
- OHS can help those who need One-Time Assistance:
  - 1st month rent/Security within FMR (Fair Market Rate) only
  - Household items/Furniture
- Eligibility for One-Time Assistance:
  - Must meet all OHS eligibility and have documentation in place
  - A letter in place stating the need for the One-Time Assistance
  - Proof of lease
  - If participant needs rent/security- W-9 from a landlord/landlord agreement form

Moving From One Unit to Another

- Participants are eligible to move once they complete an annual lease
- Participants must contact their HS 3 months prior to end of lease to begin the search process, participants are required to assist in the search of a new unit
- Moving allowance is available should the participant have no other way to move their items (last resort)
- HS must complete an end of lease inspection (photos) and discuss with the landlord the security deposit return
- Pending security return, will determine if a new security will be able to be issued

Discharge Of OHS Participants

- Voluntary housing subsidy
- Loss of participant eligibility
- Loss of Medicaid eligibility
- Re-institutionalized for more than 3 months
- Begin to receive another subsidy
- Violate OHS program rules or fail to pay rent

Discharge of OHS Participants

- Do not supply required annual documentation
- Fail to complete any aspect of lease process
- Fail to pay rent or utilities
- Fail to meet the participation agreement
- Does not maintain monthly contact with HS
- **HS will work with the individual to ensure a safe discharge**

Discharge Notices

- Hospitalizations
  - Participant must inform HS when institutionalized at any time
  - HS will issue a standard 90-day discharge notice and continue to follow up with 60-day and 30-day notices.
  - HS must keep track and ensure letters go out accordingly.
  - HS will track hospitalization dates in the hospitalization tab on the database
- Unit issues
  - Unresolvable issues with the landlord
  - Non-payment of rent
  - Eviction
  - 60-day letter followed by a final 30-day letter
- Loss of eligibility
  - No longer Medicaid eligible

Working Together with NHTD/TBI Waivers

- Participants who meet OHS eligibility can be referred
- Housing Specialist and Service Coordinator work together to house individuals
  - Constant communication/meetings/emails
  - Work on timeline for service plans and housing time frames (lease signing)
- CTS available from NHTD/TBI should be used prior to any CTS from OHS.

Rapid Transition Housing Program (RTHP)

- Rapid Transition Housing Program (RTHP) **provides rental subsidies** for **high-need Medicaid beneficiaries**
  - Previously known as Nursing Home to Independent Living (NHIL)
  - Medicaid Redesign Team (MRT) initiative funded by the Department of Health (DOH) and administered by the New York Association on Independent Living (NYAIL).
- RTHP **ensures seniors** and **people with disabilities** can afford **accessible**, **safe**, **sanitary**, and **sustainable** housing in the community.
  - Each participant will be assigned a **Housing Specialist (HS)** and an **Independent Living Specialist (ILS)**

How does RTHP work?

- Provides ongoing rental subsidy
- Locate units that are **at or below Fair Market Rate (FMR)** set by **HUD**
- Individuals are **required to pay 30%** of their income and utilities (if not included)
- Individual's income must be at **Extremely-Low Income** as determined by **HUD Annually**
- **Community Transition Services (CTS)** are available to **pay for furniture**, **essential household furnishing**, **small e-mods**
- **ILSs provide wrap around services** to ensure participants are **connected to providers/resources**

RTHP Structure

- Housing Specialists and Independent Living Specialists staffed at ILCs in all regions
- RCIL Fiscal Intermediary
- NYAIL Staff-
  - Director of Housing Programs
  - Program Coordinator
  - Support Service Coordinator
  - Account Clerk

RTHP Eligibility

- **Medicaid members** with **one or more documented chronic physical disabilities** and have **two or more chronic conditions** (e.g., asthma, diabetes).
- Are referred as **homeless high-utilizers**
- **Priority** will be given to those who are **awaiting an organ transplant** and **need** emergency housing to meet waitlist requirements.

RTHP Referrals

- Who can make referrals:
  - Hospitals
  - Managed Care Organizations (MCO)
  - Medical Respite
  - Performing Provider System (PPS)
  - Skilled Nursing Facility (SNF)

  Referral forms are on our website at: https://ilny.us/programs/rapid-transition-housing.

RTHP: Information Needed to Determine Eligibility

- **Written Verification** from **Doctor/hospital** discharge paperwork/health home/MMCO of:
  - Chronic Physical Disability
  - 1st Chronic Disease
  - 2nd Chronic Disease
- **Written Verification** from hospital, MCO, medical respite, PPS, SNF of:
  - 2 or more Inpatient Stays in Past 12 Months; or
  - 5 or more ED Visits in Past 12 Months; or
  - 4 or more ED Visits and 1 or more Inpatient Stays in Past 12 Months; or
- **Proof of Identity**
- **Proof of Age**

Eligibility continued…

- **Verify Medicaid enrollment**, documentation from local DSS office
- **Income documentation**
- **Verify** participant run through **state and federal sex offender registries**
- **Verify** participant run through **NYS Inmate Population Information Search**
- **Written description** of why the participant needs RTHP assistance.
- Include **evidence of participant's current housing**, or **evidence of participant's living situation** prior to program entry:
    1. Nursing home/hospital **discharge plan**; or
    2. Attestation by other community organizations that participant is homeless, **include the name of the shelter or location where person has been observed to sleep** and the number of days the participant has been observed to be homeless

RTHP Housing Specialist Role

- Complete intake
- Determine eligibility
- Locate and secure units, inspection: units are to be within FMR (Fair Market Rent) for the area
- Provide needed items (deposit, 1st month rent, CTS dollars)
- Maintain monthly contact
- Annual unit inspection
- Assist with problem solving
- Links within community for services
- Maintain program database
- Resource for Landlords

RTHP Independent Living Specialist Role

- **Collaborate** with applicant's **Discharge Planner**, **Care Manager and/or Service Coordinator** to ensure services and supports are available to serve the individual
- Prior to discharge, work with individuals to **develop an Individualized Service Plan** (ISP).
- **Establish monthly contact** to ensure participants have the needed service in place and are working.
- **Provide independent living skills training**, individual advocacy and other ongoing services as needed.

Community Transition Service Dollars (CTS): What's Covered

- **The cost of moving** essential furniture and other belongings through a licensed, certified (by NYS Dept. of Transportation) moving company.
- **Security deposits, broker's fees, application fees**, and redecorating fees required to obtain a lease on a unit.
- Grab bars, portable ramps, and **minor accessibility modifications.**
- Set-up **fees or deposits for utility** or **service access** (e.g. telephone, electricity, heating).
- **Basic essential furnishings** (e.g. bed, table, chairs, essential food preparation items and eating utensils; including delivery and assembly)

Additional OHS and RTH Information

- Referral forms and Regional Contacts on NYAIL website:
- http://www.ilny.org/programs/ohs
- http://www.ilny.org/programs/rth
- Or contact:

  Valerie Brennan, Director of Housing Programs
  - 518-465-4650 vbrennan@ilny.org
- Local Independent Living Center