NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

2022

SUPPORTIVE HOUSING GUIDELINES

Table of Contents

Supportive Housing Guidelines

I. Applicability

These Supportive Housing Guidelines apply to the operation of permanent supportive housing units funded by the New York State Office of Mental Health (OMH), either through direct contract or through Local Government Unit (LGU) contracts. Supportive Housing settings include scattered-site or single-site developments, specifically including units developed under OMH's Supportive Single Room Occupancy (SP-SRO) initiatives or the Empire State Supportive Housing Initiative (ESSHI).

II. Target Populations

All individuals served in OMH Supportive Housing must be at least 18 years of age, have a primary diagnosis of serious mental illness (SMI) as per the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), and experience substantial impairments in functioning in several areas of role performance due to their clinical condition, for an extended duration on either a continuous or episodic basis. Qualifying adults are dependent on treatment, rehabilitation, and support services to maintain functional capacity. (See the definition of "serious mental illness" in the Glossary). Although there are no income requirements for Supportive Housing eligibility, Residents generally have low or very low income. Most individuals living in Supportive Housing receive Supplemental Security Income (SSI) due to their mental illness.

Individuals eligible for admission to Supportive Housing include those being referred from priority settings. These include persons being discharged from State-Operated Psychiatric Centers or state-operated residential programs; persons being discharged from Article 28 psychiatric inpatient hospital care; young adults being discharged from Residential Treatment Facilities or Children's Community Residences; Residents of OMH-licensed housing, adult homes, nursing homes, voluntary or municipal homeless shelters or individuals living on the streets; persons with high-cost Medicaid use; the forensic population; and persons under an Assisted Outpatient Treatment order. Additionally, OMH and localities may identify other priority populations and eligibility criteria through Requests for Proposals (RFPs) and/or the Single Point of Access (SPOA/SPA) process.

Please note there may be additional contractually-based housing eligibility criteria or requirements depending upon the area of the State or the specific housing initiative through which the housing units were awarded. For example, in NYC, the submission and approval of the HRA 2010E housing application is currently required for most types of OMH-funded housing.

III. Supportive Housing Description

Supportive Housing is intended to ensure that Resident options in choosing preferred long term or permanent housing are enhanced through:

1. Increasing the availability of safe and affordable housing options;
2. Ensuring the provision of community integration and tenancy stabilization services necessary for Residents to succeed in their preferred housing, meaningfully integrate into the community, and achieve the goals they define for themselves; and
3. Providing flexibility so that Residents may remain in the housing of their choice while services change to meet their varying needs.

The following sections detail three areas to guide Residents, Providers, and the local mental health system in fulfilling these goals. These areas are: Resident Participation, Access to Housing, and Housing Support Services.

IV. Resident Participation

Supportive Housing is a person-centered housing model that emphasizes Resident choice and preference. Residents play an active role in Supportive Housing, including involvement in the choice of housing; type, frequency, and intensity of services; determining who is involved in their services; and in the exercise of their rights and responsibilities as tenants and individuals.

Residents work with Providers to choose the location and living arrangement for their housing, taking into consideration available housing options, affordability, and access to services and supports. All Residents in Supportive Housing are granted a lease, preferably directly between the tenant and the landlord. If a direct lease is not used, the Resident enters into a sublease with the Provider. Wherever possible, Residents are involved in selecting furnishings for their units. Client choice is expected to be reasonable but not unlimited when locating available housing options and furnishings.

Supportive Housing Services help Residents remain stably housed, establish community tenure, and realize the goals they set for themselves. Residents direct their service planning process as much as possible. They make choices about the goals they are working toward, the type and frequency of services, and who will be involved in their treatment. At a minimum, Supportive Housing requirements include the development of an individualized support plan, a monthly face-to-face contact, a home visit as needed based on the support plan or emergent needs but at least once every three months, and income verification at least annually. Residents are also given opportunities to develop natural community supports and peer to peer supports. The Provider conducts outreach to prospective Residents to ensure their awareness of Supportive Housing and encourage their participation.

Residents receive written Tenant’s Rights and Grievance Procedures upon enrollment in the Supportive Housing program. Receipt and acknowledgement of these forms are documented, and Providers maintain copies of these policies, signed by the

Resident, in the Resident's file. Providers review rights and grievance procedures with Residents quarterly during review of the support plan. Residents have input into the development and implementation of agency supportive housing practices. Providers should establish a formal system (such as satisfaction surveys, resident councils, etc.) to facilitate feedback from Residents.

V. Access to Housing

Access to Supportive Housing units is provided in collaboration with the local governmental unit or SPOA process. Supportive Housing staff provide outreach, assessment, and referral services to prospective Residents to ensure access to appropriate housing options and services.

Continuity of care is an important component to recovery. As such, if an individual has lost their Supportive Housing placement due to a lengthy hospitalization, incarceration, or other institutionalization, and both the individual and former housing Provider have a desire to re-establish the Supportive Housing relationship, priority status should be given to the individual for the next available Supportive Housing unit; this may be done outside the SPOA/SPA process if necessary, but with notification to the SPOA/SPA.

VI. Housing Support Services

Supportive Housing is a flexible model that delivers individualized services aimed at increasing housing stability and Resident well-being. Services are delivered in a manner which demonstrates understanding and respect for the diversity of the people being served and vary depending on the needs of the Resident. Often the need for Provider-delivered services decreases over time as the Resident becomes more fully integrated into the community. Unique features of Supportive Housing include:

- Supports are flexible.
- Housing is permanent. Residents may remain in Supportive Housing as long as they need a rent subsidy and/or housing support services and they continue to meet their responsibilities as tenants.
- There are no program attendance or treatment requirements.

The services that are delivered by housing Providers include: determining if an individual is eligible for Supportive Housing; conducting an individual housing needs assessment; developing an individual housing support plan; helping the individual with establishing a household; applying for entitlements; becoming acquainted and integrated within the local community; helping Residents understand their rights and responsibilities as tenants; instruction and assistance with resolving apartment and building maintenance issues; providing linkages to community resources and health home care coordination; and household management and budgeting assistance to ensure that rent and other expenses are paid.

The Supportive Housing approach is intended to foster integration of Residents into the existing community services system. It is not intended that Providers be the sole sources serving Supportive Housing Residents in the community. Rather, the focus of Providers should be to deliver those services necessary to establish the Resident in their housing and maintaining that housing until the services and rent stipend provided by the Provider are no longer needed or can be provided by transitioning the Resident to other public housing subsidies or an affordable housing setting with local support services. This coordination of services is particularly critical in situations where the population to be served in Supportive Housing is a population "most in need" of service (e.g. individuals who are living in the streets or shelters, long-term psychiatric center Residents) who may require a period of very intensive services when they first enter Supportive Housing. It is important that Providers work closely with the local governmental unit, county or SPOA/SPA entity, Health Home entity and other community service Providers to advocate for Residents to receive the services they require while residing in Supportive Housing. While recognizing that some Residents may not require additional community supports, non-residential services such as Health Home Care Management, Assertive Community Treatment (ACT), Adult Behavioral Health Home and Community Based Services (BH HCBS)/Community Oriented Recovery and Empowerment (CORE), Personalized Recovery Oriented Services (PROS) and other complementary mental health services, may be needed to maintain an individual in the community.

In order to facilitate care coordination, OMH expects regular communication between the Provider and the involved Health Home care coordinator and/or mental health services Provider, particularly to report observations and any needs identified during home visits. This communication is important to advocate for additional services that may be needed such as Mobile Integration Team (MIT) or ACT. In addition, Providers should be knowledgeable about affordable housing opportunities for recipients in their community. Based on individual needs and preferences, the local service system and/or care manager should provide the Resident access to a full range of support services, including, but not limited to:

- Employment support
- Mental health and substance abuse treatment
- Assistance with obtaining entitlements
- Health care
- Emergency services
- Health Home Care Coordination
- Transportation

Documenting Services

To ensure that Supportive Housing services are delivered in a manner consistent with the above-stated principles, Providers should collaborate with the Resident to develop a person-centered, strengths-based support plan that includes the Resident's

goals and objectives. The plan should be developed within 30 days of Resident move-in and should be reviewed with the Resident every three (3) months. The goal of the support plan is to identify the services and supports needed for the Resident to live successfully in the community and achieve the highest level of independence. It should address Resident access to preventive, ongoing, and emergency services; the frequency of planned contact with the Resident; and the date of the next support plan review. The plan should identify supports which will be provided through Supportive Housing and supports to be provided through other community-based resources. The support plan should be reviewed for appropriateness in light of the Resident's needs and adjusted as necessary every three months. If the individual is stable and their needs have not changed, or the information contained in the support plan is still relevant and no changes are needed, the Provider should document that status during the quarterly review. Housing support plans should be made available to the Resident, Field Office staff, or the LGU upon request. Providers should develop policies and procedures for making the Resident's housing records available to them upon request.

Supportive Housing staff should conduct and document a minimum of one face-to-face contact with each Resident per month, or more as needed or indicated in their individual support plan. At least one contact per quarter should occur in the Resident's home to enable the Provider to see the living environment. Other contacts may occur at a location judged convenient by both the Resident and Supportive Housing staff person. Residents' needs may change over time, and additional contacts may be necessary. Providers must maintain records regarding all contacts with Residents, including a description of supportive services provided, if any, during a contact. Providers should also document any interaction with Health Homes, Managed Care or Long Term Care Plans, other service providers, and collaterals that the Provider engages with the Resident's consent. Supportive Housing staff must document every contact with the Resident, whether it occurs face-to-face or telephonically, as well as any other contact which impacts the Resident's housing situation (e.g. landlord, care manager).

Progress notes should follow principles of documentation generally accepted in the human services field and should include, at a minimum, the following elements:

- Date, type, mode and place of contact with the Resident;
- A description of the encounter and the supportive services, including Community Integration Skill Building and Tenancy Stabilization Services, provided if any;
- A summary of issues addressed during the contact (e.g. independent living skills, family, income/support, legal, medication, educational, housing, interpersonal, medical/dental, vocational, engagement in clinical and/or community resources and services);
- Resident's response and status/progress in view of support plan;
- Supportive Housing staff's observations and impressions;
- Any referrals or other follow up to implement or adjust support plan;
- Full name, title, and signature or electronic signature using credentials of the Supportive Housing staff person that provided the contact described in the progress note.

At times, Providers may use gift cards as a mode of promoting independent living skills, providing household management assistance and consumer education. In these instances, Providers must document the recipient and amount of the gift card, and retain receipts or other record of the item(s) purchased, signed by the Resident, for auditing and claiming purposes. If receipts are not received from the Resident, a notation should be made to that effect. Prepaid cards must relate to the Resident's support plan.

VII. Provider Responsibilities

Through the development and operation of Supportive Housing, Providers play a crucial role in improving lives and ending homelessness. To this end, Providers should work expeditiously to secure apartment units, or assist Residents in locating suitable apartments, and transition individuals into the unit upon receipt of referral and acceptance into the program. Providers offer assistance to Residents in lease negotiations and reviewing and understanding lease terms. The Provider should ensure that Residents are afforded the same rights and responsibilities as other tenants.

Providers should develop written policies and procedures for rent collection, rental arrears and terminating tenancy, which should be included in the Resident packet upon admission and discussed with the Resident. If housemates are involved, the Provider will facilitate cooperative housemate agreements on bill payments, division of household responsibilities, etc. The Housing Provider must document proof of eligibility at time of admission. This documentation should remain in the Resident's file for the duration of their stay. Residents are advised that support staff should have access to their apartment for periodic visits and annual income verification, and that non-compliance may jeopardize the Resident's Supportive Housing rental stipend and support services. The Provider should also provide a formal grievance procedure to Residents.

When challenges arise in Supportive Housing, the Provider should utilize and document an array of strategies and interventions to prevent someone from being evicted, such as referrals to Adult Protective Services or other community-based services, holding case conferences, etc. Providers should develop a mechanism to identify and follow up on consumers who are at high risk of losing their housing. Indicators of risk may include rental arrears, refusal of home visits, hoarding or other unsanitary apartment conditions, unmanaged medical conditions, frequent visits to the Emergency Room, etc. The policy should include a mechanism for housing staff to bring such concerns and observations to program management, to develop strategies for intervention and/or additional services.

Providers should instruct Residents on how to identify and address emergency situations including, but not limited to, when to call 911 or other emergency services and staying safe when heat advisories or evacuation orders are issued. Providers should ensure that individuals have means to contact emergency services and have a process

for handling Resident emergencies after hours and on weekends. Every Provider should have plans in place to contact and assist Residents during area-wide emergencies such as hurricanes, other natural disasters or after a catastrophic event, and review such processes with Residents. It is also especially important for the Provider to provide ongoing support to Residents and landlords concerning housing-related issues during and after an emergency.

Providers are responsible for ensuring safe and habitable apartments. All Supportive Housing units should be located in buildings with governmental documentation of habitability that certifies the legal use and occupancy of the building and its units. Such documentation includes Certificates of Occupancy, Rental Certificates, or other local or municipality documentation that proves that the unit has been inspected and is approved for residential use. All units should have adequate heat and hot water and should be properly maintained by the landlord. The Provider bears primary responsibility for advocating for tenants and working with landlords to ensure that Residents' apartments remain safe and habitable, and that repairs are completed promptly.

The Provider often plays a dual role in helping the Resident maintain an amicable tenant/landlord relationship. As an advocate for the Resident, the Provider should ensure that the tenant's rights are guaranteed by the lease and under applicable law and that the Resident receives treatment equivalent to other tenants. Providers should advocate, or work with the Resident to have them advocate, that the lease include provisions that rent may be withheld if the landlord fails to maintain the unit in habitable, good working order. However, the Provider should also be aware of the rights and concerns of the landlord, and should work with the tenant to meet tenant responsibilities. Providers should educate Residents about landlord/tenant law and establishment of tenancy rights by guests; what it means to be a good neighbor; and the potential ramifications of not abiding by the terms of the lease.

Providers are expected to maintain occupancy in Supportive Housing at a 90% occupancy rate. OMH may reallocate units when significant vacancies exist. Providers are responsible for maintaining service delivery records in accordance with established supportive housing record-keeping and reporting requirements.

VIII. Operating Subsidy

Providers may utilize funds from the operating subsidy to resolve situations that place the Resident at risk of not meeting their basic needs, including the loss of housing. These funds are not intended to replace emergency funds available through the Department of Social Services or other sources, and Providers should make every effort to access such funds before utilizing Supportive Housing funds to resolve emergency situations. Consistent with the Supportive Housing Contract and Budgeting Guidelines, eligible expenditures for these funds include:

- Furniture replacement or storage;

- Rent payment if someone is hospitalized and has no other resources or if someone's roommate moves out and a portion of the rent cannot be paid (time limited to 3 months);
- Minor repairs, if not the responsibility of the landlord;
- Emergency food, clothing, medications or medical supplies;
- Utility arrears;
- Other reasonable housing related emergency problems or life needs which, if not addressed, could cause the Resident to lose the housing.

Note that these payments and assistance are not to be provided on an ongoing basis, or where other entitlements or resources are available. Providers are afforded the flexibility within the operating subsidy to utilize these funds for such contingencies as needed. However, Providers must budget adequately to ensure that sufficient funds for such emergency purposes are available across all individuals being served in Supportive Housing in a timely manner to meet the intent of these guidelines. Furthermore, Providers are expected to document and claim these expenditures appropriately and in accordance with the Budgeting Guidelines.

IX. Staffing

Supportive Housing staff should have a combination of education, experience, and skills to work effectively with persons with serious mental illness. Providers are encouraged to hire peers or individuals who have personal experience with the mental health system. Agencies should ensure that staff persons receive initial and on-going training and supervision, are culturally competent, and to the extent possible, reflect the Residents being served. Training competencies should include an understanding of mental illness and co-occurring disorders, engagement strategies, wellness self-management, and motivational interviewing, among others. Staff should be knowledgeable about the full array of services and community resources that will help Residents remain in stable housing. In order to provide person-centered, flexible housing support services identified above, Providers are expected to keep a minimum staff-to-resident ratio within the range of 1:20 to 1:30 for scattered-site supportive housing, based on the level of need of the individuals being served. More intensive staffing ratios are expected for single-site supportive housing (SP-SROs).

X. Rental Stipends

Supportive Housing provides rent support to assist Residents in securing affordable, decent housing at a reasonable cost, and to encourage landlords to accept individuals with mental illness as low financial-risk tenants. Whether housing is accessed in publicly-funded developments or in the open market, the provision of a rent subsidy will be necessary in most cases. Funding for Supportive Housing rent stipends is made available to the Provider through the Supportive Housing contract (through OMH or the LGU) and the rent stipends should be paid directly by the Provider to the

landlord. The stipend should not be paid directly to the Resident since a direct payment could jeopardize other client entitlements (e.g., SSI).

Providers should utilize the United States Department of Housing and Urban Development (HUD) current Fair Market Rents and the local housing authority's utility allowances as a guideline for determining reasonable rental costs. Residents in Supportive Housing pay no more than one of the following toward reasonable rent and utility costs:

- 30% of the SSI Living Alone rate;
- 30% of net wages; or
- Allowance for those on Public Assistance (the portion of the Public Assistance intended for shelter will go towards rent. Residents who receive Public Assistance are also eligible for a utility allowance).

The amount of rent paid by the Resident varies as the Resident's income changes; the rent stipend varies accordingly. Residents' contribution towards rental amount and reasonable utilities should not exceed the total cost of the rent and utility amount of the apartment unit (see rental stipend worksheet and examples below).

Individual stipend amounts should be calculated based upon the difference between what the Resident can pay and the sum of the rent and reasonable utility costs for the unit. Utility costs are defined as costs for heat (where applicable), water, gas, and electrical service. Telephone, cable, and internet costs are not considered to be utility costs. "Reasonable" utility costs can be determined by contacting the local municipal housing authority for a copy of their utility allowances. Local public housing agencies (PHAs) maintain a schedule of utility allowances by housing type for the Section 8 program. Providers should visit the HUD website periodically to confirm the most current utility allowance. To determine the amount to allow for a reasonable amount of utility consumption given a particular type and unit size of housing for OMH Supportive Housing, the local PHA should be contacted for the schedule of utility allowances and Providers should then subtract $10.00 from the PHA rates to determine the reasonable cost for each apartment's utility allowance under the OMH Supportive Housing model. If apartments are shared by two or more Supportive Housing Residents, the utility allowance should only be applied once for the overall household utility expense.

Household composition may vary, and in some cases, Supportive Housing Residents may share a household with a spouse or domestic partner, family, or with unrelated individuals. In these scenarios, responsibility for the rent should be divided proportionally. Family members or roommates are expected to contribute a proportional share of the rent. For example, in a household consisting of one Supportive Housing Resident and a spouse, roommate or partner who is not receiving services, each would be responsible for 50% of the rent. A household consisting of a Supportive Housing Resident, their adult child, and a roommate, each would be responsible for a third of the rent. In all instances, the Supportive Housing tenant's contribution toward the portion of the unit's rent for which he/she is responsible would be limited to 30% of their income. The Supportive Housing stipend would be used toward the remainder of the tenant's

share (Please refer to the Rental Stipend Worksheet examples appended to these Guidelines). Minor children in the household who receive entitlements, are expected to contribute toward household expenses, whether or not they are the Resident's children. Those family members, including minors, that do not have earned income are expected to apply for all applicable public benefits and contribute the portion designated for shelter to offset a proportional share of the rental cost.

When two or more Supportive Housing Residents share an apartment, the rental obligation should be divided between the tenants on a proportional basis, according to the number of individuals that will share the apartment. Under the Supportive Housing model, no more than three individuals receiving a Supportive Housing stipend can share an apartment. Each individual would then be eligible for a stipend, based on the methodology detailed in the "Resident Rental Stipend Worksheet".

The Supportive Housing model requires that the Resident contribute 30% of their adjusted income (as defined in Attachment A) toward the total cost of their rent and reasonable utility costs, and that the Resident cannot be required to pay more than that amount without prior OMH approval. Occasionally, a Resident will request an apartment with rent that exceeds 30% of their income. Before approving any such housing requests, Providers must prepare documentation, including a justification, assessment of the Resident's ability to afford the unit, and Resident's attestation. These should be maintained and reevaluated upon lease renewal.

The rent and utility costs for each Resident should be reflected on a "Resident Rental Stipend Worksheet" (see Attachment A) for scattered-site programs. Single-site housing projects (SP-SROs and ESSHI) may use Attachment A, or a similar rent calculation sheet as applicable and/or required by capital funders, or other agreements applicable to the housing project. On at least an annual basis, a worksheet identical or substantially similar to Attachment A must be completed for each individual receiving a rent stipend so that income changes can be appropriately addressed and supporting documentation reflecting the change (e.g. pay stub, Social Security correspondence, etc.) is provided. In single-site supportive housing (SP-SROs), an alternative rent calculation worksheet may be substituted if required by LIHTC regulatory agreements, or other capital funders. More frequent updating of a worksheet is optional, but may become necessary, if for example, the Provider becomes aware of a change that would affect the Residents' ability to pay.

Residents of Supportive Housing are encouraged to develop independent budgeting skills to support their independence. In the event the Resident needs a representative-payee, she/he should be encouraged to utilize natural supports such as family members or friends to serve in this role. If family or friends are not available or appropriate to serve as a representative payee, Residents should be encouraged to contract with a qualified organization for this function, of which the housing Provider may be one.

The Social Security's Representative Payment Program provides financial management for the Social Security and SSI payments of beneficiaries who are incapable of managing their Social Security or SSI payments. The Social Security

Administration (SSA) has developed a Guide for Organizational Payees and a Guide for Individual Representative Payees to help those that serve as representative payees understand their duties and responsibilities as a payee. These documents can be obtained through the Social Security Administration. Providers should understand these roles and help educate the Resident on these roles.

XI. Facilitating Resident Access to Housing Subsidies

Providers should facilitate Resident access to HUD Section 8, Continuum of Care (Shelter Plus Care) or other housing subsidies when available. Where possible, priority should be given to negotiating access to housing developed with public capital funds (e.g. Office of Temporary and Disability Assistance, HUD, etc.). OMH works with various publicly funded housing agencies to encourage interagency cooperation in housing development. OMH also encourages Providers to facilitate access to housing developed by publicly-funded housing agencies and for-profit housing developers. Localities throughout the State receive direct federal funding through the HUD Section 8 program to provide rent subsidies for eligible Residents. Most Supportive Housing Residents are eligible to receive such assistance and Providers should assist Residents with the application process. If a Resident does receive a Section 8 Voucher, Providers should assist and encourage Supportive Housing Residents to choose apartments where the landlord is willing to accept Section 8 payments. Please note, in New York City it is illegal for a property owner with six or more units in a building to refuse a Section 8 Voucher.

In the event that a Resident receives a voucher and the landlord is not willing to accept Section 8 payment, the Provider will encourage the Resident to secure an apartment where the landlord is willing to accept Section 8. However, the Provider cannot require the Resident to move into a Section 8 apartment. It is the expectation that when a Section 8 voucher, or other long term permanent housing subsidies become available, this subsidy will replace the OMH subsidy. Based on the needs of the individual and the appropriateness of alternative mental health services, the Supportive Housing Provider should work with the Resident and the local mental health services network (through the SPOA/SPA where available) on discharge planning to ensure that responsibility for serving the Resident is assumed by non-residential service Providers.

The federal government, in conjunction with state or local governments, also provides funding for housing subsidies under the Continuum of Care program. Under this program, federal housing subsidies are provided for qualifying “special needs” populations. The federal subsidies are matched with service funding from either the state or the locality. While Section 8 and Continuum of Care are the most commonly used means of securing non-OMH funded rental assistance for Supportive Housing Residents, there may be other funding assistance available within a particular locality or for a particular project. Providers should inquire with their OMH Field Office or county regarding the availability of any such funding.

Providers should be aware, however, that non-OMH organizations that fund housing subsidies may condition this funding on meeting certain requirements that may differ from Supportive Housing guidelines. Nothing in these Supportive Housing guidelines should be interpreted to contradict or supersede earlier agreements with other agencies, such as LIHTC regulatory agreements, where both apply to the same units. Note that any conflicts with such agreements anticipated, discovered, or not otherwise addressed in the Supportive Housing guidelines should be brought to the attention of OMH to be resolved as needed in collaboration with other funders on a case-by-case basis. Providers should be aware of these conditions or requirements and determine whether to pursue it in the context of the Supportive Housing.

XII. Lease Arrangements

It is preferable that the leases for Supportive Housing units should be solely in the Resident's name whenever possible. However, it is recognized that in some circumstances this is not possible, and the Provider may appear as a third-party signatory to the lease, or even be the sole signatory to the lease. (In this latter circumstance, the Provider would sublease the apartment to the Resident.)

Regardless of the lease arrangement, all tenants should have a current lease or sublease with the same rights and responsibilities as market-rate tenants. The lease and/or sublease should not include responsibilities which are not typically found in standard market-rate leases (house/program rules, policies about visitors, requirements to adhere to support plan, etc.)

XIII. Furnishings

Wherever possible, Residents should be involved in selecting furnishings for the units they will occupy. OMH Field Offices may provide a recommended checklist of basic furnishings upon request, although all items on the checklist should not be construed as a requirement for the Provider or a guarantee for Supportive Housing Residents. When securing scattered site Supportive Housing units, Providers should include air conditioners with the initial set of furniture and furnishings if central air conditioning is not provided in the unit. In general, these expenditures, including furniture, should be viewed as non-recoverable expenses incurred to assist the Resident in moving to independent community living. Except for SP-SROs, where furniture has been provided via other funding sources, furniture should remain with the individual in Supportive Housing. For individuals in shared units, minimally the bedroom furniture should remain with the individual leaving the unit. The Resident is not, therefore, expected to reimburse the Provider for these expenses upon leaving Supportive Housing. A Provider may use Supportive Housing funds to cover replacement furniture, new or used, as needed.

XIV. HCBS Settings Rule Compliance

In order for individuals to receive Home and Community-Based Services (HCBS), the setting in which they reside must be compliant with all aspects of the settings final rule issued by Centers for Medicare and Medicaid Services (CMS). Supportive Housing providers are required to comply with all aspects of the HCBS settings final rule, issued by Centers for Medicare and Medicaid Services (CMS). Specifically, all settings must meet the following standards/qualities:

1. Be fully integrated into the broader community to the same degree of access as individuals not receiving Medicaid HCBS, including:
    a. opportunities to seek employment/ work in competitive integrated settings;
    b. engage in community life;
    c. control personal resources;
    d. receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;

2. Be selected by the individual among options including non-disability specific settings and an option for a private unit in a residential setting;
    a. the options are documented in the HCBS person-centered service plan;
    b. the options are based on the individual's needs, preferences, and for residential settings, resources available for room and board;

3. Ensure an individual's rights to privacy
    a. Ensure and individual's rights to dignity and respect;
    b. Ensure an individual's rights of freedom from coercion and restraint;

4. Optimize but do not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact;

5. Facilitate individual choice regarding services and supports, and who provides them;

6. Have a person-centered planning process facilitated by the HCBS care manager that provides necessary information and support to individuals to ensure recipients can direct their housing support plan as much as possible. Person-centered planning shall meet the following requirements:
    a. Includes people chosen by the individual
    b. Is timely and occurs at times/locations convenient to the individual
    c. Assists the person in achieving outcomes they define for themselves in the most integrated community setting they desire
    d. Ensures delivery of services in a manner that reflects personal preferences and choices
    e. Helps promote the health and welfare of those receiving services
    f. Takes into consideration the culture of the person served
    g. Uses plain language that can be understood by the person
    h. Includes strategies for solving disagreements

i. Is reviewed/revised when circumstances change or at request of the individual
j. Identifies individuals´ strengths, preferences, needs (clinical and support), and desired outcomes

7. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the jurisdiction's landlord/tenant law or equivalent;

8. Each individual has privacy in their sleeping/ living unit:
a. units have entrance doors lockable by the individual, with only appropriate staff having keys;
b. individuals sharing units have a choice of roommates in that setting;
c. individuals have the freedom to decorate their sleeping or living units within the lease or other agreement;

9. Individuals have the freedom and support to:
a. control their own schedules and activities;
b. have access to food at any time;

10. Individuals are able to have visitors of their choosing at any time; and

11. The setting is physically accessible to the individual.

XV. Moving and Absences

Although Supportive Housing Providers may initially house a single adult, life situations change. Residents may get married, reunite with children, or decide to live with a significant other. These are normal life events. A Resident who wishes to live with non-recipients on a long-term basis (usually minor or adult children, spouse, or domestic partner) should notify the housing Provider and discuss the implications of this life event. This includes determining if the housing is appropriate, any income eligibility limitations the housing may have, such as those imposed in Low-Income Housing Tax Credit (LIHTC) buildings, along with expectations on rent calculation and the lease or sublease.

Residents in a Supportive Housing program who wish to move to a different supportive apartment should work within the parameters of their lease or sublease, funding availability and geographic area covered by the Provider. Rental stipends are not transferable to a different supportive housing Provider should the Resident elect to move. If a Provider determines that the rental unit is no longer suitable, the Resident should be involved in the process of finding a new apartment and moving.

In the event that a Supportive Housing Resident experiences an unavoidable absence from their apartment, it is expected that the Provider take necessary action to ensure that the Resident does not lose the apartment during their absence. Housing is

not lost during unforeseen absences of short duration. Providers should contact the Field Office as soon as possible to discuss such cases and make a determination of whether it is reasonable to hold the bed based on the specific situation and the needs of the Resident. If the Resident has income, he/she would still be required to pay 30% of their income towards rent and utilities during the absence.

XVI. Cessation of Supportive Housing

Goal Achievement

The goal of Supportive Housing is to provide assistance that enables Residents to remain housed in the community until they no longer need such assistance. There is no length of stay expectation for Supportive Housing. However, as increased independence is the aim of the Supportive Housing approach, Providers should work with Residents to include in their support plans goals and strategies to secure the means to pay their rent without the use of a Supportive Housing stipend (either through employment or another publicly funded stipend).

A Resident is considered to be in Supportive Housing as long as the Provider is paying a rent stipend on their behalf and/or providing Supportive Housing services (Providers are required to offer services to individuals who are receiving Supportive Housing rent stipends). OMH recognizes that there may be a period after the Resident begins to receive another rent stipend or after he/she becomes employed and able to pay the full rent for their apartment when the community services provided by the Provider may still be required, particularly if the non-residential services the Resident requires are not yet in place. The Provider should work with the Resident and the local mental health services network (through the SPOA where available) on transition planning to ensure that responsibility for serving the Resident is assumed by non-residential service Providers as soon as possible after the individual is no longer receiving a Supportive Housing rent stipend.

In the event that a Resident elects to leave the Supportive Housing unit and move to an independent apartment in the community, any refund of the rent, security or utility deposits should be placed at the Resident's disposal to pay those costs for the new unit.

Resident Refusal to Pay When Supportive Housing Provider is Landlord

If a Resident refuses to pay their portion of reasonable rent and utilities and the Provider is the landlord, the Provider should utilize and document an array of strategies and interventions to prevent someone from being evicted. As a best practice, OMH encourages Providers to establish a written rent collection and eviction policy that: outlines the interventions and progressive steps; is consistently implemented; and is explained with, signed by, and provided to the tenant upon entry into the program. The Providers' policy must be consistent with applicable landlord-tenant laws. In the event

eviction proceedings are warranted, the Provider should ensure that such action is carried out in accordance with local laws and procedures. The Provider should work with the Resident to pursue alternative housing options.

Resident Refusal to Follow Program Expectations

In the event that a Resident refuses to follow program expectations and the Provider is the landlord, the Provider should utilize and document use of the array of strategies and interventions discussed above in order to assist the Resident. If a Resident refuses to follow program expectations and the Provider is not the landlord, the Provider should coordinate with the Local Service System and Field Office in order to assist the Resident with accessing a full range of support services to support their ability to remain successfully housed without the rental stipend support and services provided by the Provider.

Cessation for Reasons Other than Goal Achievement

Prior to terminating a Resident from Supportive Housing, the Provider should discuss the specific situation with the Field Office. In addition, the Provider should be able to document all interventions used (e.g. case conferences, referrals, and attempts) to re-engage the Resident.

Supportive Housing Provider's Responsibility if Landlord Evicts Resident

In the event that a Resident is evicted from their apartment by a landlord other than the Provider, the Provider should assist the Resident to locate alternative housing that matches their preference and goals, taking into consideration available housing options, affordability, and access to services and supports. Eviction from one's apartment is not necessarily grounds for the Provider to discharge a Resident from the Supportive Housing program. In the event of an eviction, the role of the Supportive Housing Provider is to advocate for the Resident, provide supports, and identify and link the Resident to appropriate services which may include housing. However, remaining in Supportive Housing cannot be guaranteed. Providers should help the individual to understand their responsibilities as a tenant and help facilitate resolution of housing issues to prevent an eviction.

XVII. Cost Allocation Guidance for Mixed-use Integrated Housing Projects

OMH recognizes that in many integrated, mixed-use supportive housing projects, Supportive Housing funds are being utilized within projects involving mixed funding sources and/or multiple populations. Certain funding sources may be limited to serve certain populations.

Furthermore, OMH understands that such integrated housing programs include low-income Residents and that these programs are intended to operate in an integrated fashion to support independent living in the community. As such, there are basic support and services that will have some tangential benefit to the low-income Residents who are at risk of homelessness and face other similar life challenges to those with a mental illness. OMH recognizes that integrated housing models are the preferred approach, and services to clients should not be managed in a segregated fashion since these would be administratively burdensome and have adverse impacts countering the intent of the program supports to the Residents.

Therefore, when operating such integrated, mixed-use housing projects, Supportive Housing Providers need to demonstrate an acceptable approach to accounting for the appropriate use of funds. OMH will consider a logical methodology to cost allocation provided that it is based on data (e.g. time studies, staff caseloads, per unit basis, etc.). In the case of a per unit basis, cost allocations and contract close-out reconciliations will be calculated proportionally by actual filled bed utilization according to the funded populations served under separate contracts*. If using an alternative methodology, OMH reserves the right to require additional information for review and approval to confirm that costs will be allocated appropriately. *Note that this approach would not apply to a single ESSHI contract that is serving multiple populations.

XVIII. Oversight and Monitoring

Contracts for Supportive Housing may be directly with OMH (including ESSHI and SP-SROs) or through local government units, funded by OMH through State Aid Letter. OMH staff or LGU staff, as applicable, will engage in periodic monitoring of Supportive Housing programs. This may include but is not limited to:

- review of tenant records (leases, rent calculations, referrals, etc.);
- program and services review (policies and procedures on services engagement, support plans, etc.);
- property review (inspection of units, maintenance records and practices, etc.); and
- interviews with tenants and residential staff.

Supportive Housing Providers are expected to make such records available and make reasonable efforts to allow access to units upon request. Monitoring will typically occur at least once during the term of the contract, or more frequently if corrective action is required.

ESSHI projects may involve tenant populations other than individuals with a serious mental illness. Therefore, monitoring for such projects may be conducted collaboratively, involving staff from other ESSHI Interagency Workgroup agencies with expertise and oversight responsibility particular to the population(s) served in the project, and/or monitoring tools developed by those agencies.

The Child and Adult Integrated Reporting System (CAIRS)

The Office of Mental Health maintains a system that tracks all admissions and discharges in OMH-funded housing, including Supportive Housing. Entries to this system are made by the Provider at the time the Resident is admitted via the web-based CAIRS application. This system contains information concerning the Resident's demographics (e.g. age, race, sex). When a Resident is admitted to or discharged from a program, the Provider is expected to update the system within seven days of the event. This is called an Episode, and includes the date the Resident moves in or leaves, as well as the type of residential setting they were referred from or are moving into.

In addition, programs participating in Medicaid-billable Tenancy Services must document the licensed practitioner of the healing arts (LPHA) recommendation for services in CAIRS.

CAIRS data is used to provide information concerning Resident demographics, program performance indicators, program vacancy rates, and other factors that OMH officials, localities, and voluntary agencies can access to better inform administrative oversight of residential programs. All contracted residential Providers, whether through local county contract or direct state contract, are required to participate in the CAIRS system. Providers are referred to their OMH Field Office for more information concerning this system.

XIX. Medicaid-Billable Rehabilitative and Tenancy Support Services (SPA 20-005)

Some supportive housing services are billable under the Medicaid rehabilitative services benefit, as authorized in Medicaid State Plan Amendment #20-005. Known as *Community Integration and Tenancy Stabilization Services* (referred to as Rehabilitative and Tenancy Support Services), these services are furnished to assist individuals who may have previously resided in institutional settings or nonpermanent housing (including emergency housing) to develop independent living skills and establish and maintain integration within the broader community. They focus on reducing the disabling symptoms of mental illness and substance use disorder and managing behaviors resulting from these behavioral health conditions or other medical or developmental conditions that jeopardize an individual's ability to live in the community. Services are individualized and provided face-to-face (including telehealth where appropriate) with the Resident, or through collateral contacts for the benefit of the individual. They include arranging connection to community supports; encouraging building of natural supports necessary for individuals to remain in the community; and providing skill-building services that promote community tenure.

The services available under Rehabilitative and Tenancy Support Services fall into two categories: Community Integration Skill-Building Services, and Stabilization Services. Community Integration Skill-Building Services are intended to support individuals who are transitioning into housing and establishing community integration. These services include needs assessment, community resource coordination, treatment planning, and rehabilitative independent living skills training. Stabilization Services are

intended for individuals already residing in Supportive Housing to assist them to remain stably housed. Stabilization Services include tenancy support planning, rehabilitative independent living skills training, community resource coordination, crisis planning, and crisis intervention. (See Glossary for definitions of the specific services identified above.)

Services that are specifically excluded from being Medicaid-billable Rehabilitative and Tenancy Support Services are educational, vocational and job training services; room and board; habilitation services; and recreational and social activities. These services may still be provided in Supportive Housing, but they are not Medicaid billable services.

A cornerstone of supportive housing service delivery is that services are tailored to the individual and based on Resident need and desire to participate. As such, providers are not required to provide Rehabilitative and Tenancy Support Services to all individuals in participating programs.

Lastly, note that individuals with SMI and functional deficits related to their SMI may benefit from and receive a variety of state and Medicaid-funded rehabilitative services to enable them to meet the same or different goals, such as independent living, or educational, vocational, or interpersonal goals. These other services, such as Mental Health Outpatient Treatment and Rehabilitative Services (formerly “Clinic Treatment”), Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), Behavioral Health Home and Community Based Services (BH HCBS), or Community Oriented Recovery and Empowerment (CORE) Services may be provided to Residents during the timeframes in which they are receiving Rehabilitative and Tenancy Support Services. These services are not duplicative because individuals may require services to address symptoms or improve functional impairments impacting domains other than housing stability or a higher intensity level of services than those Supportive Housing Providers can provide to ensure community integration. Supportive Housing providers should coordinate their activities with other service providers to maximize the individual’s rehabilitation and restoration of functional abilities.

Provider Participation in State Plan (20-005) Rehabilitative and Tenancy Support Services

With the exception of ESSHI, all unlicensed housing programs funded by OMH (including SP-SROs and scattered-site Supportive Housing) may choose to participate in and receive an enhanced rate for Rehabilitative and Tenancy Support Services. CR-SROs are also eligible programs for participation. Participating CR-SROs should follow the requirements outlined in this document specific to Rehabilitative and Tenancy Support Services, but should otherwise continue to follow all requirements under 14 NYCRR Part 595). Participation in Rehabilitative and Tenancy Support Services by Supportive Housing Providers is voluntary, and Providers may withdraw from participation at any time. Providers should notify OMH of their willingness to participate, or of their subsequent withdrawal, through the process identified in additional guidance.

Supportive Housing Providers not already enrolled in the Medicaid program as a participating Provider must do so prior to participation in Rehabilitative and Tenancy Support Services.

Authorization for Rehabilitative and Tenancy Support Services

In order to bill for Rehabilitative and Tenancy Support Services, there must be a recommendation for such services completed by a Licensed Practitioner of the Healing Arts (LPHA). The recommendation should be based on a clinical determination that the services could be beneficial to help an individual establish or maintain housing stability. This authorization must be completed prior to billing for services, and must be renewed every three years. The LPHA recommendation should be documented on the standardized template issued by OMH and be documented in CAIRS. The recommendation form must be kept on file in the individual's residential record.

Appropriately credentialed staff within a Housing agency may complete the LPHA recommendation, or the agency may take steps to secure the recommendation elsewhere. Providers should obtain recommendation renewals at least one month in advance of the current recommendation's expiration to ensure there is no gap in billing.

Documentation of Rehabilitative and Tenancy Support Services

Rehabilitative and Tenancy Support Services must be documented consistent with Section VI above. With the exception of Crisis Planning or Intervention, services should align with the goals and services identified in the support plan. All services delivered in participating programs (not just Medicaid-billable services) must also be documented in CAIRS on a monthly basis. Service documentation should be completed within 15 days of the end of the month.

XX. Conclusion

This document is intended to replace any previous version of OMH's Supportive Housing Guidelines. The statements contained herein are reflective of the Supportive Housing model in general and are not intended to create or impose requirements that are regulatory in nature. Nothing herein is to be construed as legal opinion, nor is it intended as a substitute for the legal advice of counsel. Questions concerning application of these guidelines to situations that may be encountered in delivering Supportive Housing may be referred to the OMH Field Office.

Glossary

Community Integration and Tenancy Stabilization Services (referred to as Rehabilitative and Tenancy Support Services): Specific supportive housing services furnished to assist individuals to develop independent living skills, remain stably housed, and become integrated within the broader community. These services are Medicaid reimbursable under the State Medicaid Plan.

Community Integration Needs Assessment: Conducting an individual needs assessment to identify an individual's strengths, preferences, and barriers to maintaining housing stability and community integration. This service occurs at the time of enrollment in a supportive housing program.

Treatment Planning: Individualized support planning, based upon the Community Integration Needs Assessment, that identifies Providers or services outside of the housing program that will assist with housing stability and maintaining community integration. This service occurs with a newly-enrolled supportive housing Resident, and is consistent with the initial support plan development identified in Section VI above.

Tenancy Support Planning: Individualized support planning with individuals to review, update, and modify the existing support plan. This service is available to individuals established in a Supportive Housing program, and is consistent with the support plan review process outlined in Section VI above.

Rehabilitative Independent Living Skills Training: Psychosocial rehabilitation and skills training to help Residents develop and maintain skills necessary to live successfully in the community. These services include: coaching and skill building to assist individuals in identifying and securing resources; understanding their rights and responsibilities as tenants; forming supportive relationships; accessing needed services and community resources; participating in community integration opportunities; and developing readiness for permanent housing. This service is available to both newly enrolled and established Residents, and includes any skill-building activity that assists an individual in establishing or maintaining housing stability.

Community Resources Coordination: Providing assistance to individuals with establishing a household, becoming acquainted with the local community, and linking to services including: health home care coordination; primary care; substance use treatment; mental health; vision/nutrition/dental Providers; crisis services; parenting resources; end of life planning; and other supports. Service includes advocacy and linkage with community resources to stabilize community

integration when community tenure is, or may potentially become, jeopardized. This service may be utilized for both newly enrolled and established tenants.

Crisis Planning: Support planning for individuals well before a crisis, or after a crisis has occurred. These services are designed to help individuals and their collaterals effectively recognize, manage, plan for, and prevent the escalation of psychiatric and/or substance use symptoms or other factors so that housing stability is not jeopardized. Specific interventions that fall under this definition include but are not limited to: assessment to determine the need for further evaluation and/or supports; safety planning; engagement with Resident's identified supports; connection to supports and services identified in the safety plan; advocacy and linkage to resources to prevent escalation; and debriefing following a crisis episode.

Crisis Intervention: Urgent and temporary support to individuals who are experiencing, or are at imminent risk of experiencing, a crisis. These services aim to interrupt and/or ameliorate acute distress and associated behaviors that threaten a Resident's housing stability, and restore them to a pre-crisis level of functioning. Crisis Intervention services may include: assessing the crisis and facilitating resolution and de-escalation; providing support for utilization of a safety plan; ensuring safety for the Resident and others; engaging collaterals; providing linkage to resources needed for de-escalation and restoration such as a crisis stabilization center, residential crisis respite, or helpline.

Community Residence/Single Room Occupancy (CR-SRO): licensed, single-site transitional housing programs with on-site staffing support. CR-SROs maintain 24-hour front desk security and make services available (such as case management, life skills training, etc.) to residents. CR-SROs participating in Rehabilitative and Tenancy Support Services are subject to the applicable provisions of these guidelines; in all other aspects CR-SROs are governed by 14 NYCRR Part 595.

Types of Supportive Housing

Scattered-Site Supportive Housing: Usually, Supportive Housing is located in rented apartments scattered throughout the community. Services to Residents of scattered-site Supportive Housing are provided by the Providers as needed by the Resident to ensure housing stability, in coordination with other services and supports available in the community including Health Homes.

Supportive Single-Room-Occupancy (SP-SRO) and Mixed-Use /Income Housing: Supportive-Single Room Occupancy (SP-SRO) housing is a form of Single-Site Supportive Housing that combines permanent housing with some on-site services. The support offered in SP-SROs is consistent with the principles

guiding all Supportive Housing. Mixed-use housing is affordable housing where supportive housing units are integrated with other affordable housing units in the same building. Generally, at a minimum, front-desk or security staff are on-site 24 hours per day.

Permanent Housing: Permanent housing is considered community-based housing without a designated length of stay where the tenant has a leased or subleased apartment unit. All Supportive Housing which falls under these guidelines is considered permanent housing.

Serious Mental Illness: In order to be considered an adult with a serious mental illness, "1" below must be met, in addition to either "2", "3", or "4":

1. Designated Mental Illness: The individual is 18 years of age or older and currently meets the criteria for a DSM-IV (or subsequent edition) psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD-CM psychiatric categories and codes that do not have an equivalent in DSM-5 or (any subsequent edition) are also included mental illness diagnoses.

And

2. SSI or SSDI due to Mental Illness The individual is currently enrolled in SSI/SSDI due to a designated mental illness.

Or

3. Extended Impairment in Functioning due to Mental Illness:
a. Documentation that the individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:
i. Marked difficulties in self-care (personal hygiene, diet, clothing, avoiding injuries, securing health care or complying with medical advice).
ii. Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
iii. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
iv. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in these areas when they repeatedly are unable to complete

simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

Or

4. Reliance on Psychiatric Treatment, Rehabilitation and Supports A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.