



NYC HOME-STAT

Stakeholder Research
Insights Report

Documenting the Journey
from Street to Home
January–May 2016



Mayor's Office of Operations
November 2017

NYC[®]

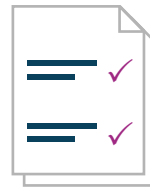
Introduction

HOME-STAT partners existing homeless response and prevention programs with new innovations designed to better identify, engage, and transition street homeless New Yorkers to appropriate services and, ultimately, permanent housing.

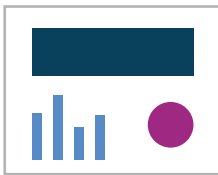
Four Components



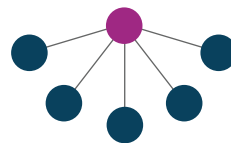
Proactive Canvassing



Quarterly
Nighttime Counts



Daily and Monthly
Public Dashboards



Case Conferencing

Since 2007, the Department of Homeless Services, the Department of Health and Mental Hygiene, and their Providers have been conducting proactive street and subway outreach to individuals who are potentially homeless throughout New York City. The teams interact with anyone they encounter, but historically their focus had been on the chronically homeless, who have lived on the street or subway for nine months of the past two years. (See more on chronicity on page 35.)

They operate under a harm reduction and housing first model, with the ultimate goal of getting individuals permanently housed. Together they have moved thousands of people to permanent housing who otherwise may have remained on the street only to further decline.

These teams – the direct service Providers with a shared expertise in serving the street and subway homeless – are central to the HOME-STAT initiative. This document details the process of their service delivery and key areas of interest related to their work as of January–May 2016. Policies and operations may have changed since then.



“Placing people in housing gives me hope. There’s nothing like giving someone the key to their apartment.”

— Outreach Worker

Process and Methodology

Interviewed

37 Government Staff

6 NYC Agencies, 1 NY State Agency

18 Program Staff

5 Providers

7 Clients

Shadowed

10 Outreach Staff

6 Outreach Teams

Process and Methodology for Research and Reporting

Throughout January and April 2016, the Design Team within the Mayor's Office for Economic Opportunity (the "Design Team"), now known as the Service Design Studio:

- Interviewed Department of Homeless Services (DHS) staff
- Interviewed DHS street and subway homeless outreach contracted Providers, including program directors, case managers, and outreach workers at:
 - Bowery Residents' Committee (BRC), contracted for subway outreach
 - BronxWorks (BW), contracted for Bronx outreach
 - Manhattan Outreach Consortium (MOC), comprised of Goddard Riverside, Breaking Ground, and Center for Urban Community Services, contracted for Manhattan outreach
 - Breaking Ground (BG), contracted for Brooklyn and Queens outreach, subcontractor to MOC for Manhattan
 - Project Hospitality (PH), contracted for Staten Island outreach
- Shadowed the Outreach Teams in the field
- Met with homeless and formerly homeless individuals who are on the street, in transitional housing, and permanently housed
- Interviewed NYPD Crisis Outreach and Support Unit (COSU) officers
- Interviewed the Mayor's Office of Criminal Justice (MOCJ) staff who manage the Safe Hub project
- Interviewed Human Resources Administration (HRA) Family Independence Administration staff
- Interviewed Housing Preservation and Development (HPD) staff from Division of Tenant Resources, Policy and Operations in Asset and Property Management, and Special Needs Housing
- Interviewed Metropolitan Transit Authority (MTA) staff
- Received report feedback from the HRA Placement, Assessment, and Client Tracking Unit (PACT)

Based on the interviews and experiences, the Design Team created "journey maps" to describe key points in the business process and worker and client experiences. On January 28, 2016, the Design Team hosted a workshop with DHS, the Providers, and other members of the Mayor's Office of Operations to validate the information contained in the journey maps and collaboratively identify areas for enhancement. The Design Team completed follow-up research and incorporated feedback from the stakeholders above. Learn more about the design process for HOME-STAT at www.nyc.gov/servicedesign

This report is organized by major steps in the street-to-home process and each includes a summary, insights, and detailed journey maps.

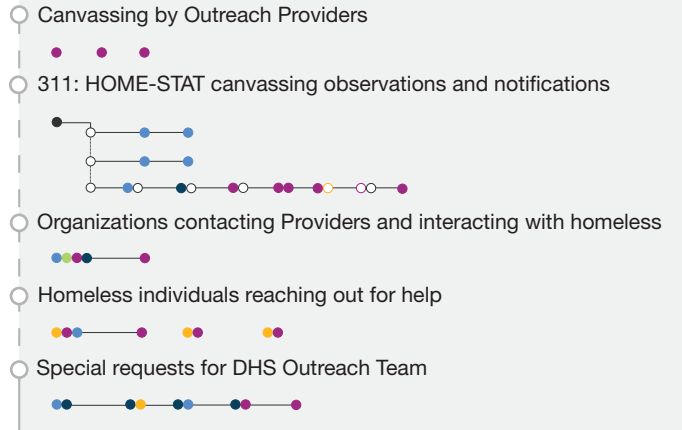
Journey Map

This overview journey map of street homeless outreach reflects the business process, and worker and client experience during the period January–April 2016 from initial observation, contact, case management, and placement in permanent housing. The map is displayed in eleven high-level sections, each with individual sub-level sections. Summaries and details for all the sections are presented in the subsequent pages.

Each dot represents an individual or agency. Each cluster of dots represents a service interaction.

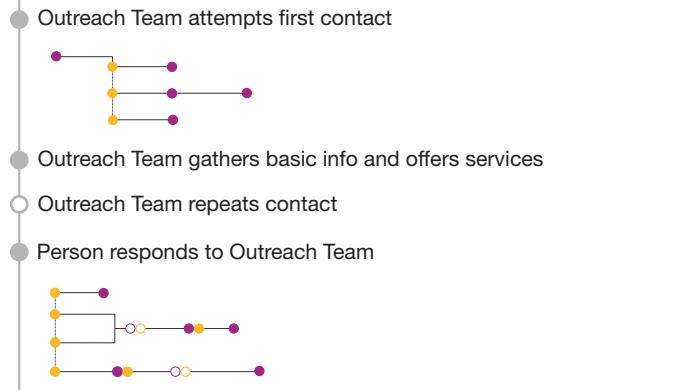
SECTION 1

IDENTIFYING STREET HOMELESS
Pages 11–17



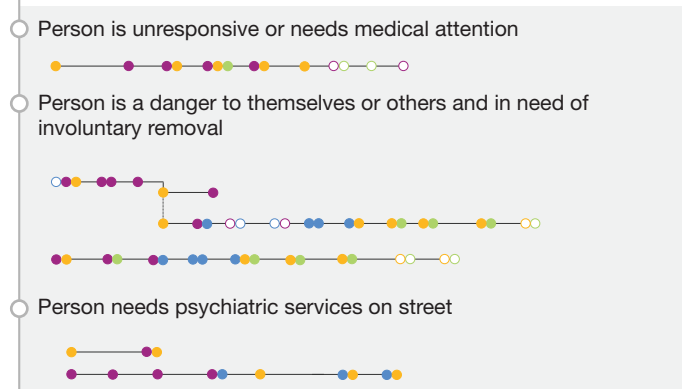
SECTION 2

CONTACT AND RESPONSE
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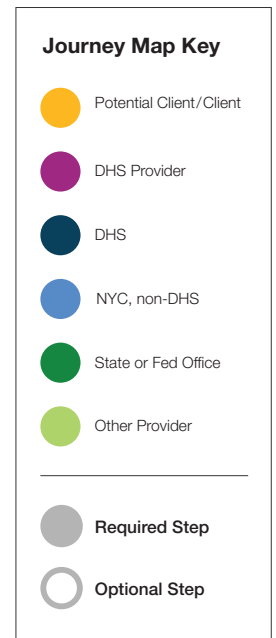
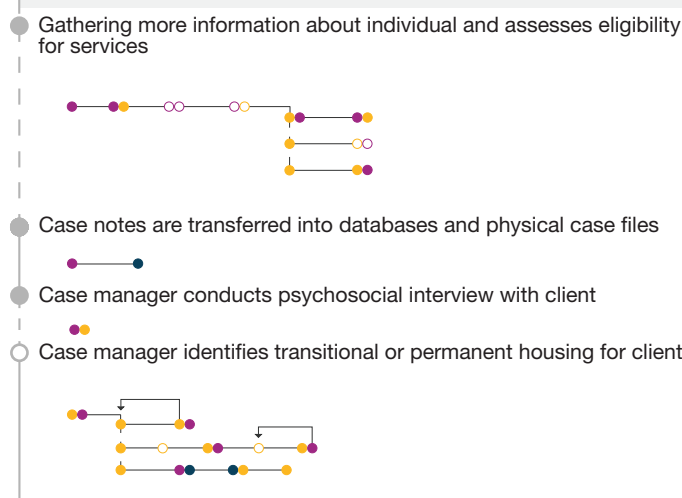
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SECTION 4

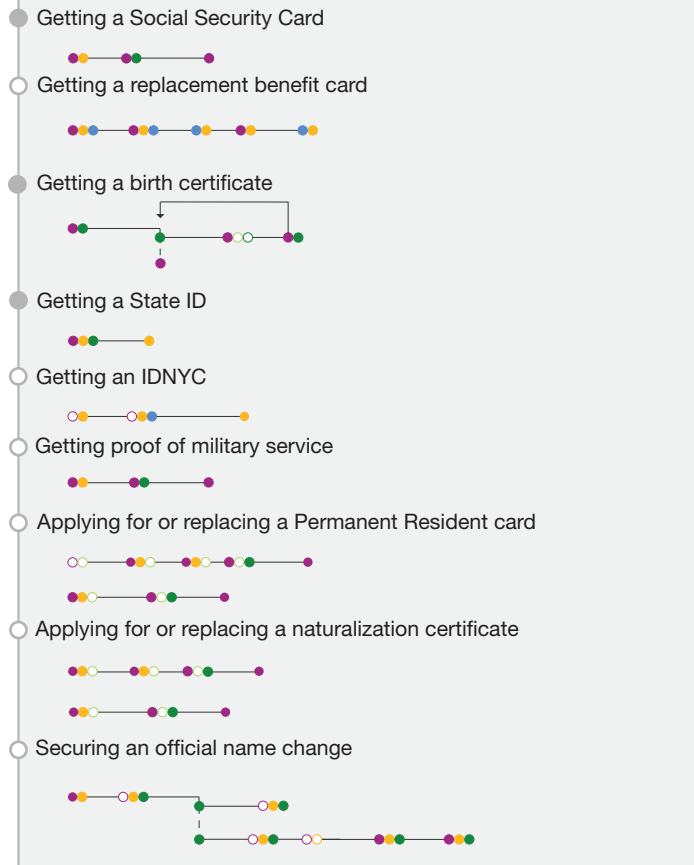
MOVING ONTO CASELOAD
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SECTION **5**

GATHERING VITAL DOCUMENTS

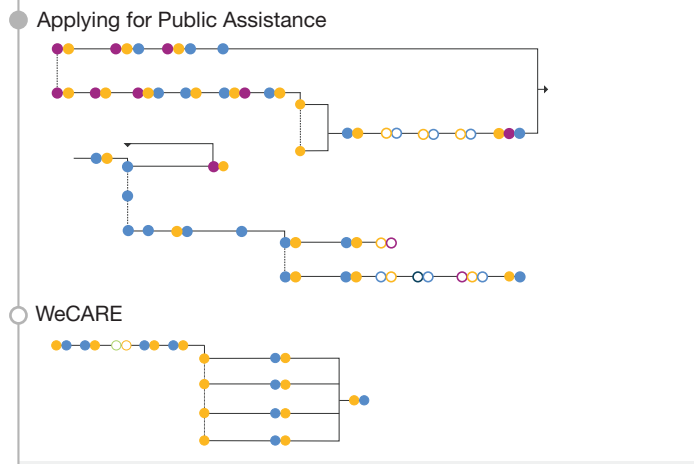
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SECTION **6**

APPLYING FOR PUBLIC ASSISTANCE

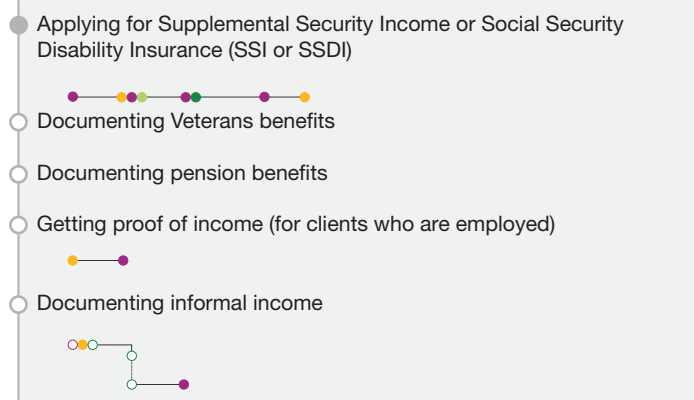
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SECTION **7**

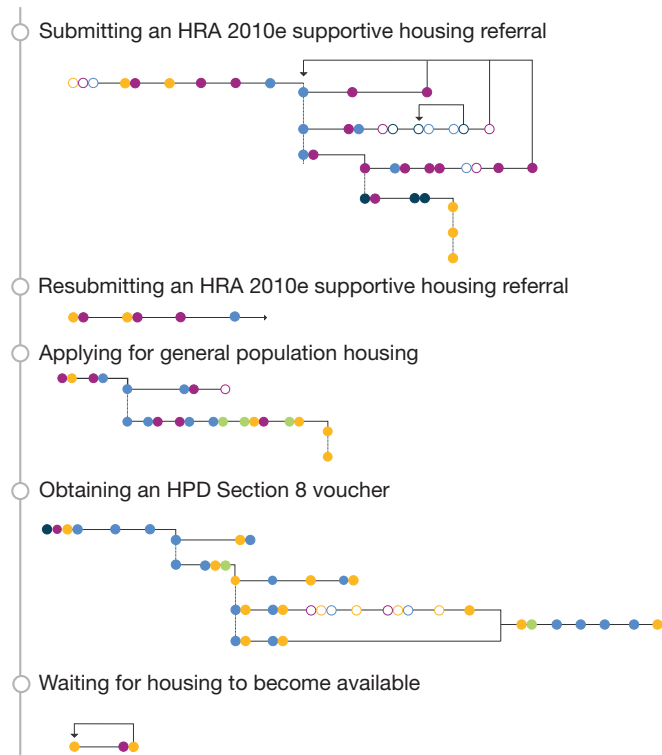
SECURING AN INCOME OTHER THAN PUBLIC ASSISTANCE

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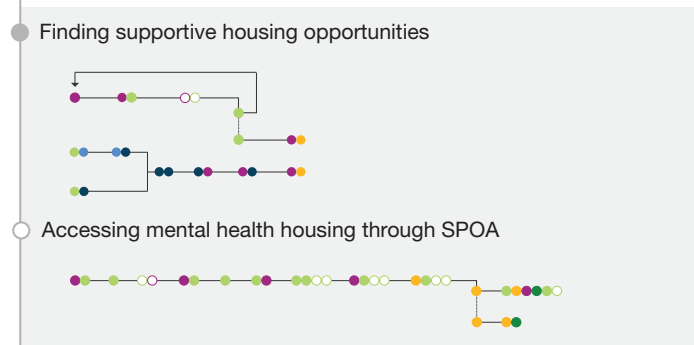
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APPLYING FOR PERMANENT HOUSING
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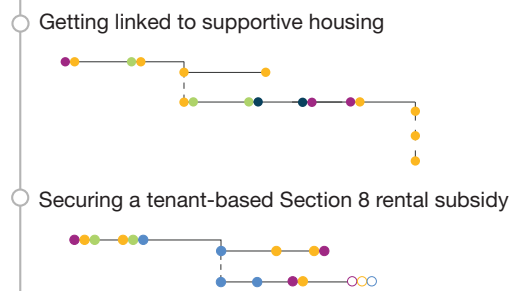
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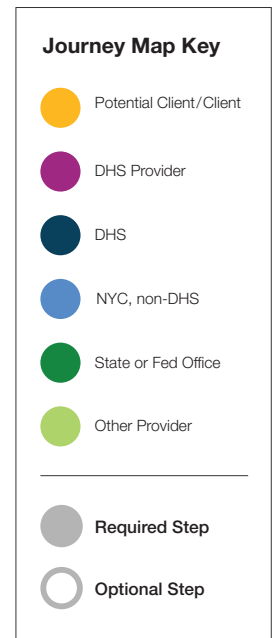
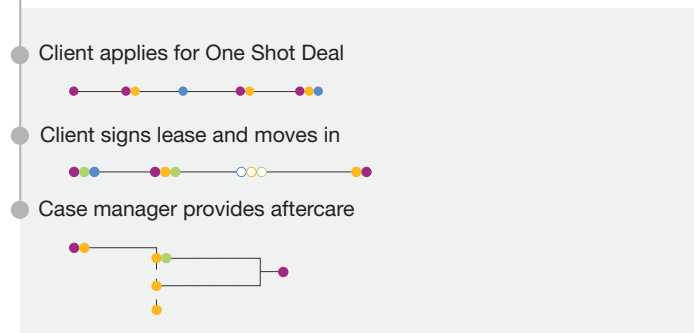
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GETTING LINKED TO HOUSING
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Section 1

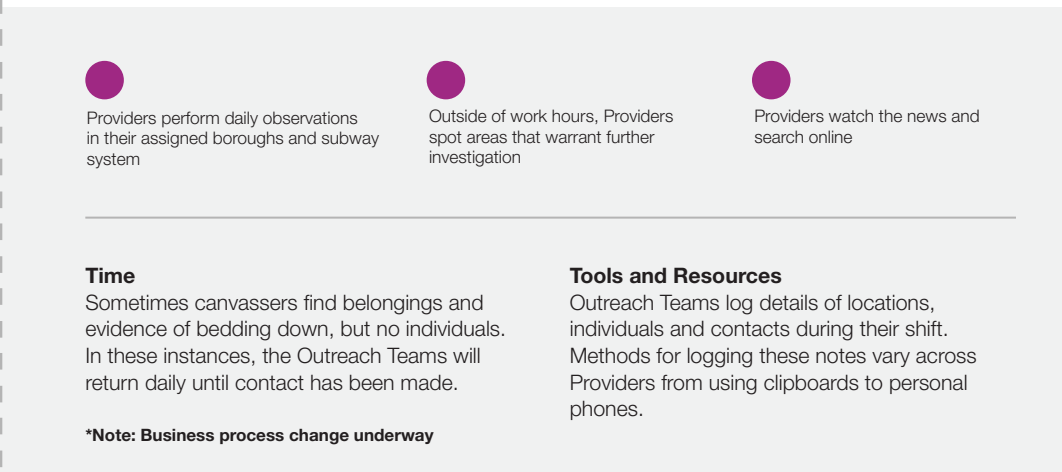
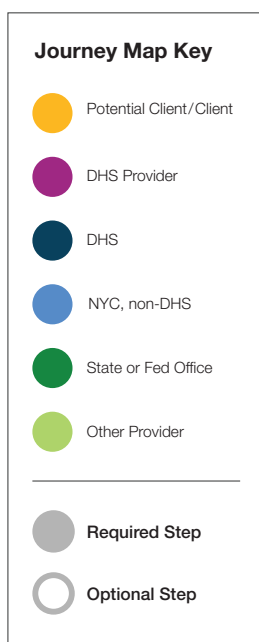
Identifying Street Homeless

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- **Canvassing by Outreach Providers**
 - **311: Public & HOME-STAT Canvassing Observations and Notifications**
 - **Organizations Contacting Providers and Interacting with Homeless**
 - **Homeless Individuals Reaching Out for Help**
 - **Special Requests for DHS Outreach Team**

Reports of potentially homeless individuals come to the City and DHS Providers through several sources. Ongoing outreach and canvassing by City and Provider teams, combined with reports from 311 and community organizations, make up the majority of reports. Some of the reported individuals are not chronically street homeless. Additionally, some homeless individuals may contact the Providers themselves to request services.

Canvassing by Outreach Providers OCCURS DAILY

The Provider Outreach Teams look for key signs that someone may be homeless, including bedding down, sleeping on a park bench, or panhandling. These individuals may not necessarily be homeless and outreach workers interact with individuals to confirm their status (see pages 21–24). (Note that this differs from the separate HOME-STAT Canvassing teams (see page 14), who do not confirm whether or not individuals are sheltered but report based on appearances.) Outreach workers also noted that some street homeless individuals tend to congregate in areas with high foot traffic from public transit lines and 24-hour stores. Some Providers have canvassing routes and others do not have capacity to canvass their full borough.* Routes are largely designated by where they believe people are and have been spotted frequently.



Canvassing by Outreach Providers (continued)

In the subway system, Outreach Teams walk the entire station and check every stairwell. The 469 stations are visited in six week intervals. They also look for doors or gates that may be ajar, and check platforms beyond the public areas. When they go down into a station, they check in with the station agent and ask if the agent has seen any homeless individuals. The team records the agent's badge number and time. Outreach Teams also ask MTA maintenance and cleaning workers about who is currently in the station and recent conditions.

Daytime subway Outreach Teams do not go onto the trains as there is a daytime decline in homeless subway ridership that does not maximize resources. The overnight subway Outreach Teams conduct joint operations with NYPD's Crisis Outreach and Support Unit and Transit District (TD), and canvass stations and subway cars at the end of the line. The Outreach Team prefers to be accompanied by law enforcement in order to do onboard outreach on a moving train. NYPD assists in waking individuals and providing transportation if someone accepts services. Outreach Teams report that the NYPD TD is not always present during outreach.

The MTA has a team to do overnight counts in some terminals and report back to headquarters with a daily list. New York City Transit (NYCT) has a group that inspects all underground rooms and makes sure they're secure—both to ensure system safety and security and ensure the safety of homeless individuals. When a homeless individual is found in a private area, they are deemed to be trespassing and the NYPD is contacted to remove the individual. The MTA also attempts to bring in BRC.

Outreach workers are often on the lookout for individuals even when they are off-duty. They sometimes spot encampments and log them to follow up on when they are back at work. Others watch the news and search online for keywords to find new individuals and also learn more about people who may be known to the Outreach Teams, but not providing information.

311: Public & HOME-STAT Canvassing Observations and Notifications

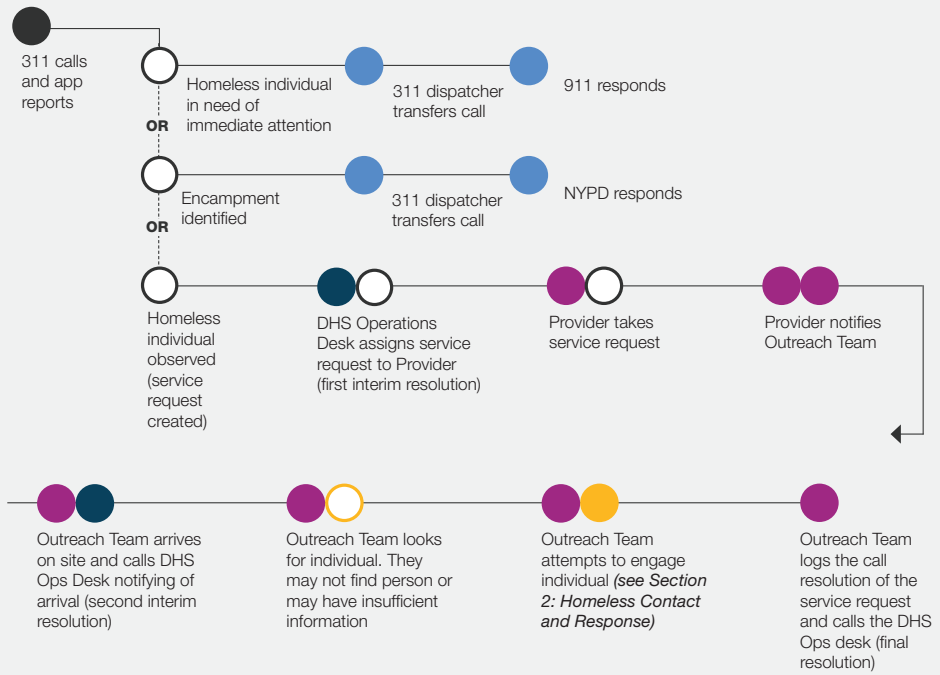
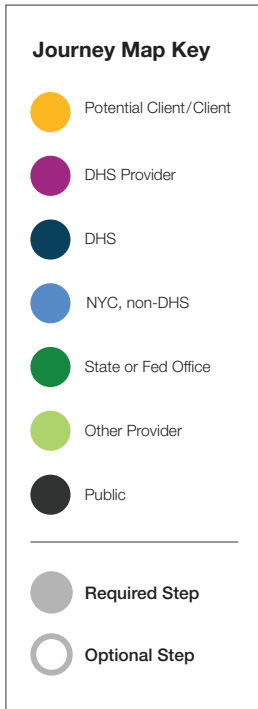
ONE-TWO HOURS

Members of the public and the HOME-STAT canvassing team report homeless individuals through 311 and the NYC 311 app. The public uses both phone calls and the 311 mobile application, and the HOME-STAT canvassing teams use solely the mobile app. Between January and April 2016, the Mayor's Office of Operations, DHS, 311, and the Providers worked to implement a new 311 process, which is reflected below. Continued enhancements are underway.



“The homeless population is a huge challenge for us, huge challenge for our employees.”

—MTA



Note: Business process change underway

Time

Providers are required to respond to their 311 calls within an average of one hour. Response times may be longer if the Provider is already engaged with an individual who needs extra attention.

Requests peak during morning commute.

Tools and Resources

Provider Outreach Teams are notified of 311 services requests (SRs) by their dispatchers who receive SRs via phone and email from the DHS Operations Desk. SRs include timestamps for when they were created, when they were assigned to a Provider, when the Provider arrived on site, and when they were closed. A final resolution describes the outcome of the SR to DHS. In addition, SRs containing information for all relevant “rapid” calls routed to NYPD are reported.

All SRs are entered in the Siebel system, and SR data can be accessed through the Citywide Performance Reporting (CPR) business intelligence tool and the NYC OpenData portal. Providers continue to maintain their own logs, as this was their only formal way of reporting prior to storing data in Siebel. Previously, reporting back to DHS was periodic, limited, and not consistent across Providers.

311: HOME-STAT Canvassing Observations and Notifications (continued)

If the person is in need of immediate medical assistance, 311 routes the calls to 911. If the call is about an encampment, 311 routes the call to NYPD. If the call is about a potentially homeless person in need of assistance, a service request is created and the call is routed to the DHS Operations desk. The DHS Operations desk assigns the service request to the appropriate Provider. Providers are required to respond to their 311 calls within an average of 1 hour. Response times may be longer if the Provider is already engaged with an individual who needs extra attention. If another person has expressed willingness to come inside, Providers may de-prioritize 311 calls in order to ensure that the first individual receives services.

311 dispositions for service requests for outreach assistance include:

- Assistance offered
- Refused assistance
- Referred to 911
- Person not found
- Insufficient information
- Out of network provider
- Out of jurisdiction

Providers offer services to anyone they encounter, however Providers report that the individuals who are found via 311 service requests are often not the chronic street homeless population.

Several Providers reported that 311 calls and app reports can be problematic if the descriptions are not detailed enough to identify an individual. Descriptions like “homeless individual” or “old lady on sidewalk” were cited as examples of 311 reports that usually do not result in finding the individual. DHS and Providers reported that their preference is to speak with the caller, as sometimes callers and people using the 311 app will give their location instead of the location of the person in need.

There can often be multiple 311 requests within an hour about a single individual or location (likely a hotspot). Providers are trying to efficiently group requests, but if a call is about the same person/location at a different time of day, they dispatch the Outreach Team again. Some Providers current outreach capacity has not been sufficient to respond to multiple calls within the average of 1 hour time limit. At the time of the report, changes to operations were being developed to address this.

DHS also reported that a number of calls unrelated to encampments are being mistakenly transferred to NYPD. These calls include 311 inquiries about potentially homeless individuals in the subways.

311: HOME-STAT Canvassing Observations and Notifications (continued)

Calls transferred to NYPD are referred to as “rapid calls,” and depend on the 311 dispatcher’s interpretation of the information provided. Providers report that many of these calls are about abandoned buildings, which the Outreach Team are not equipped to handle. The Outreach Teams are able to canvass outside of the buildings, but cannot go into the structure. Certain areas experience higher volumes of calls to abandoned buildings, including Staten Island and the Rockaways.



“This program does a lot more than any other. I tell people about this one. I love these people. These people are great, but they should notice homeless people faster, they’d save more people. A lot of people just give up.”

—Client linked with permanent supportive housing, awaiting move-in

Organizations Contacting Providers and Interacting with Homeless

OCCURS DAILY

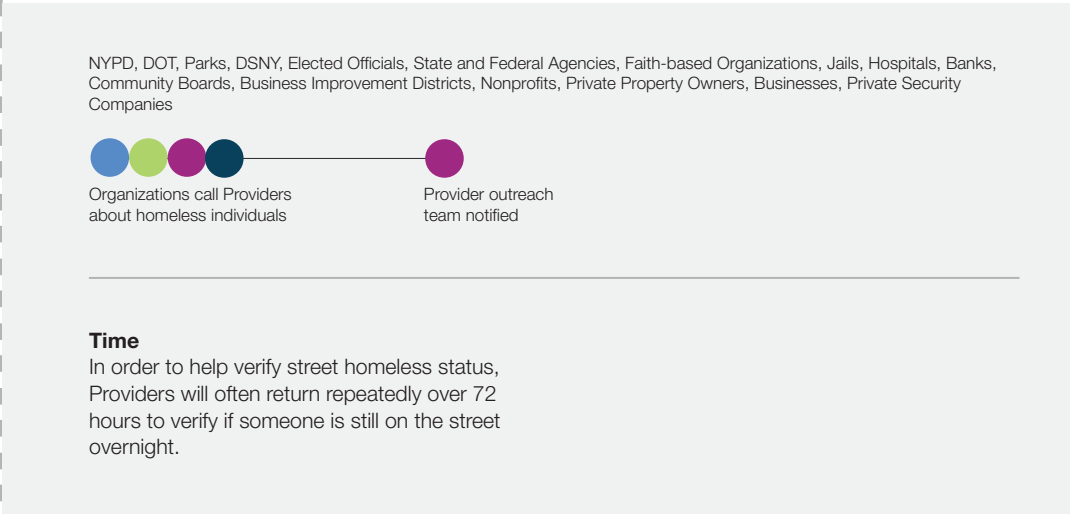
Providers are contacted directly via phone or email by the DHS Street Homeless Unit or a community organization may contact them if an individual appears to need services. These calls depend heavily on the relationship the Provider has with the referring institution and awareness of the Provider’s work within the community. Most Program Directors mentioned attending meetings with community boards, NYPD, or the Parks Department and will direct outreach efforts based on their reports.

BRC coordinates Roundtable meetings to review conditions within all of the transit districts, and discuss conditions and plan responses at every station. DHS mentioned that there are always new community stakeholders to meet.

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

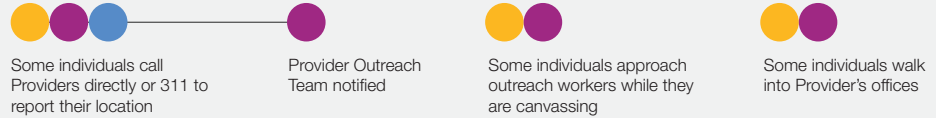




Homeless Individuals Reaching Out for Help

OCCURS DAILY

Sometimes individuals who are already known to the Providers will call, either directly or through 311 to let the Outreach Teams know where they are.



Tools and Resources

Many individuals have personal phones that they can use to contact Providers directly.



Special Requests for DHS Outreach Team

OCCURS DAILY

DHS has roles for two Outreach Team members and one driver who can respond as needed to investigate potential homeless activity. DHS staff report that these types of calls may or may not be critical, but require a rapid response. Follow-up on any requests is completed by the Providers.



Time

DHS staff say that these types of calls happen often and can disrupt primary work.

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

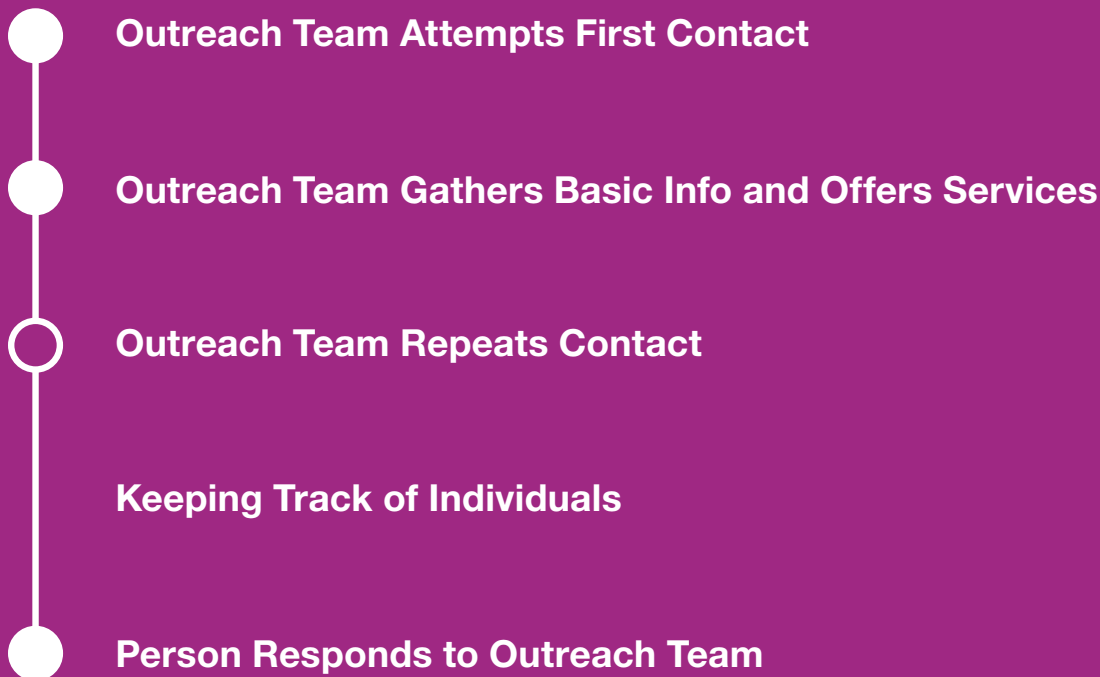
- Required Step
- Optional Step

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Section 2

Homeless Contact and Response

Staff Roles and Street Presence



Outreach Teams attempt to contact anyone who appears to be homeless. Many people are reluctant to give information initially, requiring the Outreach Teams to make repeated contacts in order to build relationships that encourage those living on the streets to share information and accept services. The Outreach Teams expressed that eventually, every person they encounter will seek help and shelter, but it is difficult to know when that time will come.

Staff Roles and Street Presence

The Providers have variations in the roles of staff who do street outreach and their appearance and presence on the street.

BRC	BRC outreach workers conduct subway outreach, and later transition to case managers once a person is deemed a HOME-STAT client. BRC also has joint clinical and outreach Teams. Outreach workers wear bright orange-branded jackets and drive branded vehicles. When clinical staff go out with outreach workers, they wear the orange-branded jackets, but if they are going out alone, they wear plain clothes.
Breaking Ground	Breaking Ground outreach workers conduct street outreach, and later transition to case managers once the individual has become a HOME-STAT client. Outreach workers wear Breaking Ground-branded jackets and drive Breaking Ground-wrapped vehicles.
BronxWorks	BronxWorks outreach workers conduct street outreach and later transition to case managers once the individual has become a HOME-STAT client. They wear a mix of BronxWorks-branded jackets and HOME-STAT vests, and drive vehicles with a BronxWorks sticker.

* Note: Business process change underway for client thresholds for case management

Staff roles and street presence (continued)

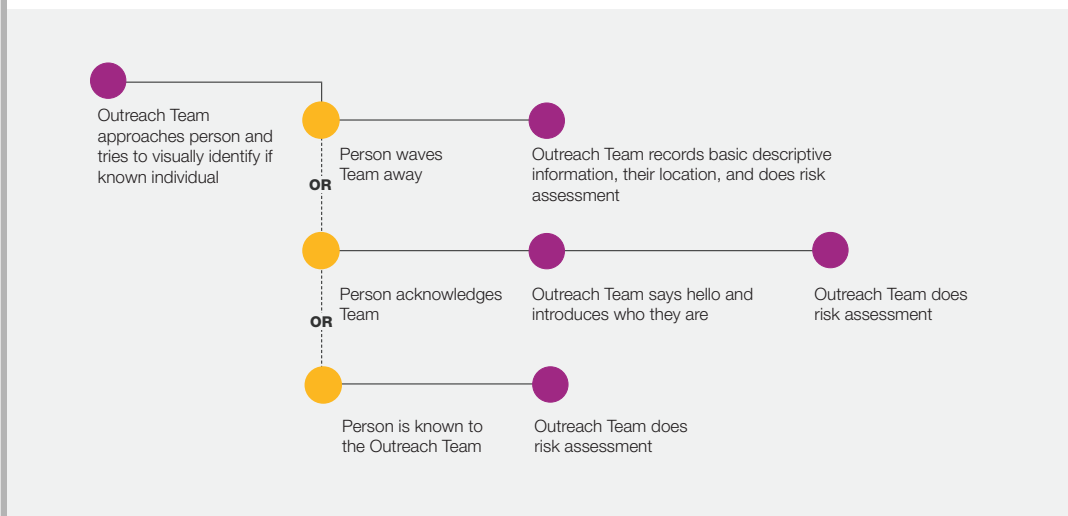
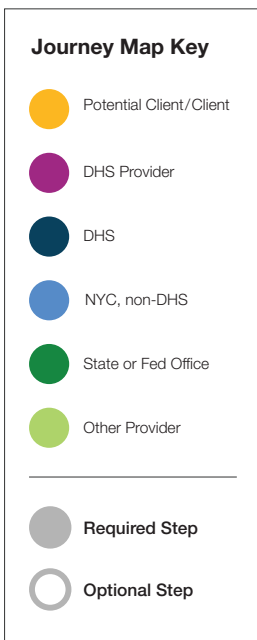
MOC	MOC case managers conduct street outreach during the day. MOC outreach workers conduct street outreach overnight. Both case managers and outreach workers wear plain clothes and drive a wrapped vehicle. NYC/DHS jackets and hats are available but not often worn.
Project Hospitality	Project Hospitality case managers conduct street outreach in addition to case management. They wear HOME-STAT vests and NYC/DHS jackets and drive unmarked vehicles.

Street teams may be more focused on case management during the day and on outreach at night. In this case, there is a hand-off between the day and night teams to ensure that staff are up to date on important cases.

Outreach Team Attempts First Contact

ONE DAY-YEARS

On first contact, Outreach Teams are attempting to gather basic information and do a risk assessment, regardless of how the person responds. Providers are tracking everyone they encounter, whether or not they are receptive to the Outreach Team. The teams log “contacts” in their respective tracking systems and in DHS’ case management system, CARES (Client Assistance and Re-Housing Enterprise System). Providers assign respectful nicknames to individuals until their actual names are known (e.g., “pink blanket” or “blue hat”). As more is known, workers progressively add more details and information. Providers and DHS report that this makes for many duplicate records as teams may have different nicknames for an individual.



Outreach Team attempts first contact (continued)

Time

Amount of time varies depending on how much the individual would like to engage. Some Providers reported knowing about street clients for over 10 years who refused to engage or accept services.

Tools and Resources

Providers log notes in the field using different tools:

- piece of paper
- personal phone/visit list
- paper/notebook away from client
- small notebook with client, and also contact sheet(s) for each “Tour” of a station

Several Providers have tried mobile data entry, but say they do not get good data and clients are put off and intimidated by devices.

Outreach Team Gathers Basic Info and Offers Services

ONE-TWO HOURS

Information is usually gathered over time. Often individuals share information in small pieces, like a nickname or a birthday, and outreach workers will build up a case file over time that can eventually be used to help the clients access services.

Standard approach in good weather conditions

Risk Assessment

Ask Status

“Are you homeless? Do you have a place to stay?”

Try to Get Basic Identifiers

Name, DOB, SSN

Offer Placement

Initial contact: Shelter, Drop-in center

After repeated contacts: Safe haven, Stabilization bed, Respite bed

Special cases: Detox, ER

Offer Office Visit

Stories from the Street

The Outreach Provider continues to attempt engagement with a homeless man with severe mental illness who has been known to them for 10 years. He has never spoken to them and the only information they have is that he used to be a doctor. This sparse information came from a since-retired police officer who befriended him many years ago.

Outreach Team Gathers Basic Info and Offers Services (continued)

Standard approach in Code Blue. Code Blue is DHS' Cold Weather Emergency Procedure when temperatures fall below 32 degrees or the wind chill is below 0 degrees (Fahrenheit). During these conditions, Outreach Teams focus closely on vulnerable clients who they deem are at greater risk of cold weather injury or death. At 20 degrees with wind-chill, the teams continue to focus on their vulnerable clients and street teams double their overnight coverage for unsheltered homeless people, who are more at risk during the cold winter months. Additionally, when the procedure is in effect, these individuals may access any of the agency's adult facilities, including shelters and drop-in centers, without going through the usual intake process.

Additional Offers and Information

- Inform individual they should not stay outside
- Offer to take them anywhere warm, including Dunkin' Donuts or the ER waiting room. Some Outreach Teams were also observed providing Metrocards to individuals, but BRC and the MTA do not condone this practice

Standard approach in Code Red. Code Red is DHS' Heat Emergency Plan, issued within 24 hours prior to the onset of a heat index reaching at least 95 degrees for two consecutive days; or temperature above 100 degrees for any period of time as predicted by the National Weather Service; or when an Excessive Heat Warning is issued. During these conditions, Outreach Teams focus efforts to protect vulnerable homeless people, who are more at risk for heat-related exposure or death.

Additional Offers and Information

- Inform individual they should not stay outside or in the subway
- Offer to take them anywhere air conditioned, including Dunkin' Donuts, ER waiting room, or cooling centers
- Offer water and sunscreen

As more information is gathered, the engagement becomes more tailored to the client's needs and situation. Offers like an office visit or stabilization bed tend to happen with clients who are already known.

The Outreach Teams use a daytime approach to let it be the client's decision to come inside, asking them if they'd like to come, rather than directing them to it. BRC provides some individuals with signed business cards with a unique number on the back. This helps them verify client reports and track individual movements. They also frequently offer dropping into the office or calling the phone number on the card. BRC offers "drop-in" hours during morning, afternoon, and evening times for clients to meet with clinical outreach workers beyond scheduled appointments.

Outreach Team Gathers Basic Info and Offers Services (continued)

Providers employ bilingual staff if language is a barrier. Sometimes Outreach Teams will use translation apps on their phones to communicate with individuals. They also sometimes call a line with interpreters provided by DHS. Outreach Teams expressed additional need for Mandarin and Creole speakers.

Outreach Team Repeats Contact

ONE DAY-YEARS

Most people require repeated contacts before the Outreach Teams can develop the rapport and trust that allows them to gather information. Building trust can often take time and is a main component of the work of Outreach Teams. The amount of time varies depending on how much the individual would like to engage. Some Providers reported knowing about street clients for over 10 years who refused to engage or accept services. Often individuals share information in small pieces, like a nickname or a birthday, and outreach workers will build up a case file over time that can eventually be used to help the clients access services.

Many individuals have experience with “the system” and Providers are working to overcome the failure of customer service, whether real or perceived. Individuals view “the system” to include government agencies and service Providers, not always making a distinction between them.

Keeping Track of Individuals

If they are able to gather basic information, Providers reference their tracking systems and/or CARES to find out if a person is known to their organization or the shelter system. It is especially hard to identify the correct case file for individuals who have not given a name. Providers attempt to add evidence to prove chronicity (see page 38), but may not always contribute to the appropriate individual’s file if they work different shifts or are less familiar with a specific geography. There are many duplicate entries in the systems that may describe the same individual.

Many Providers will designate an individual “pre-caseload,” during the period of gathering more information through repeated contacts, and have varying thresholds for this status. BRC also has a “hybrid” designation, which is for individuals who are being tracked by their overnight Outreach Team, but are not on the clinical caseload. Enhancements are underway to include all homeless individuals who are encountered three times or more, or identified as homeless by the Provider on the first or second contact as HOME-STAT clients, regardless of chronicity.



“My advice for someone living on the street is to trust the process. When (the Outreach Provider) picked me up, I was at the bottom. They were honest with me from the beginning and I knew I had to trust the process, be committed, and ask questions. In the shelters, everything is decided for you. Now, I tell people about (the Outreach Provider). I still go to places like soup kitchens and tell people that even though it’s hard, it’s possible and it’s going to be alright.”

—Permanently housed individual with over 30 years of homelessness experience

Keeping Track of Individuals (continued)

Both DHS and Providers noted that it is very common for street homeless individuals to move around. For example, people sometimes go missing and are later found again in a different place. Individuals may also be hospitalized or incarcerated without the Provider’s knowledge. Additionally, there is no formal system for transferring case files from one Provider to another.



“You never know when a client will decide to seek help. They do it on their own time.”

—Provider



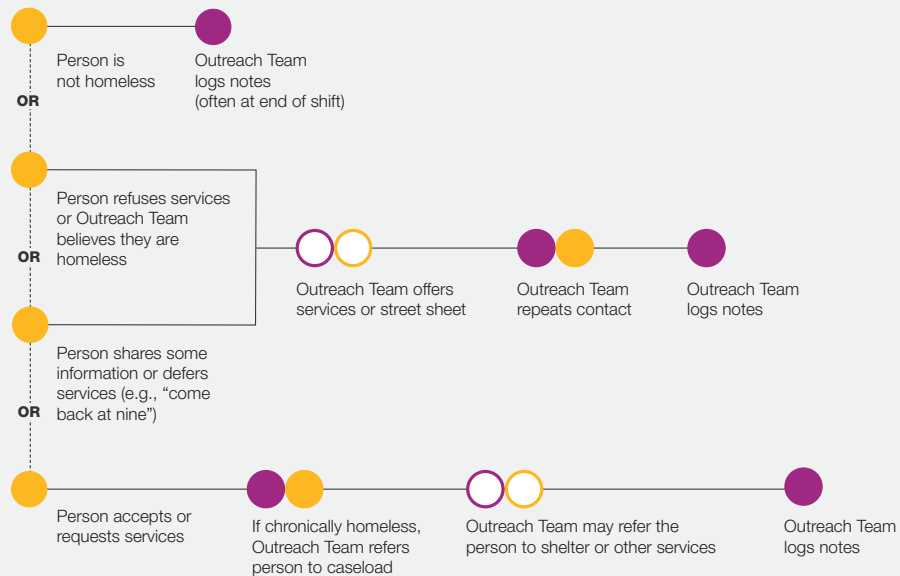
“If you hit 90 days on the street, you have an equal chance of hitting a year.”

—Provider

Person Responds to Outreach Team

ONE DAY-YEARS

Depending on how willing a person is to talk to the Outreach Teams, it can take days to years to gather more information. Many individuals walk away or ignore the Outreach Teams. At different times and across many different encounters, the same client may follow any or none of these paths. DHS and Providers report that this stage is client-driven and different for every person.



Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Tools and Resources

Providers offer “street sheets” that list borough-wide resources and services to anyone they encounter.

Person Responds to Outreach Team (continued)

Tools and Resources (continued)

Usually at the end of the shift, Outreach Teams

log notes into digital systems:

- CARES (all Providers)
- Binders and spreadsheets
- CDB
- Excel
- MOCapp
- Contact form
- Tours (note that a single worker does data entry as part of their shift and may or may not be the person who made the observations)

According to Providers and clients, there is not typically just one thing that triggers someone to accept services. Providers often cannot really discern what it was that got someone to come inside. Catalysts can include sudden changes like illness, extreme cold, or having an encampment cleared.

Providers identified a variety of signals that someone may be closer to wanting to move indoors. The person may:

- Talk about their belongings
- Ask the Outreach Team questions about Safe Havens
- Have a friend who is now coming inside
- Be willing to look at photos of Safe Havens or go on a tour
- Have made a recent change (like starting methadone treatment) and wants to get fully away from habits
- Visit a Provider's office and accept a meal there



“If you don’t have a place for them to go when they’re ready, you have to regain that moment.”

—Provider

Section 3

Health Crises, Hospitals, and Psychiatric Services



Person is Unresponsive or Needs Medical Attention



Person is a Danger to Themselves or Others and in
Need of an Involuntary Removal



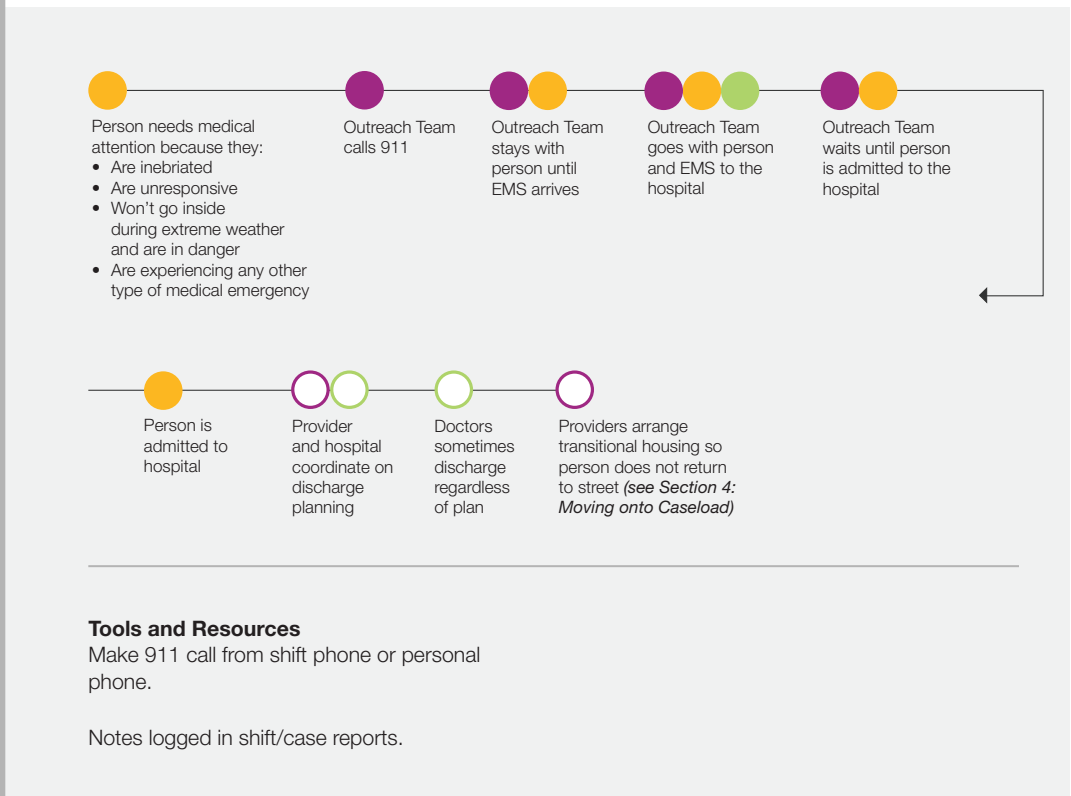
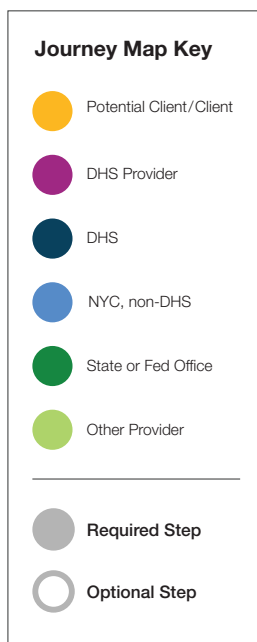
Person Needs Psychiatric Services on Street

Street homeless individuals are at great risk for medical and psychiatric emergencies due to exposure to the elements, clinical histories, and undiagnosed or untreated conditions. The Providers are trained to recognize symptoms of both physical and mental health crises and to respond accordingly.

Person is Unresponsive or Needs Medical Attention

HOURS–MONTHS

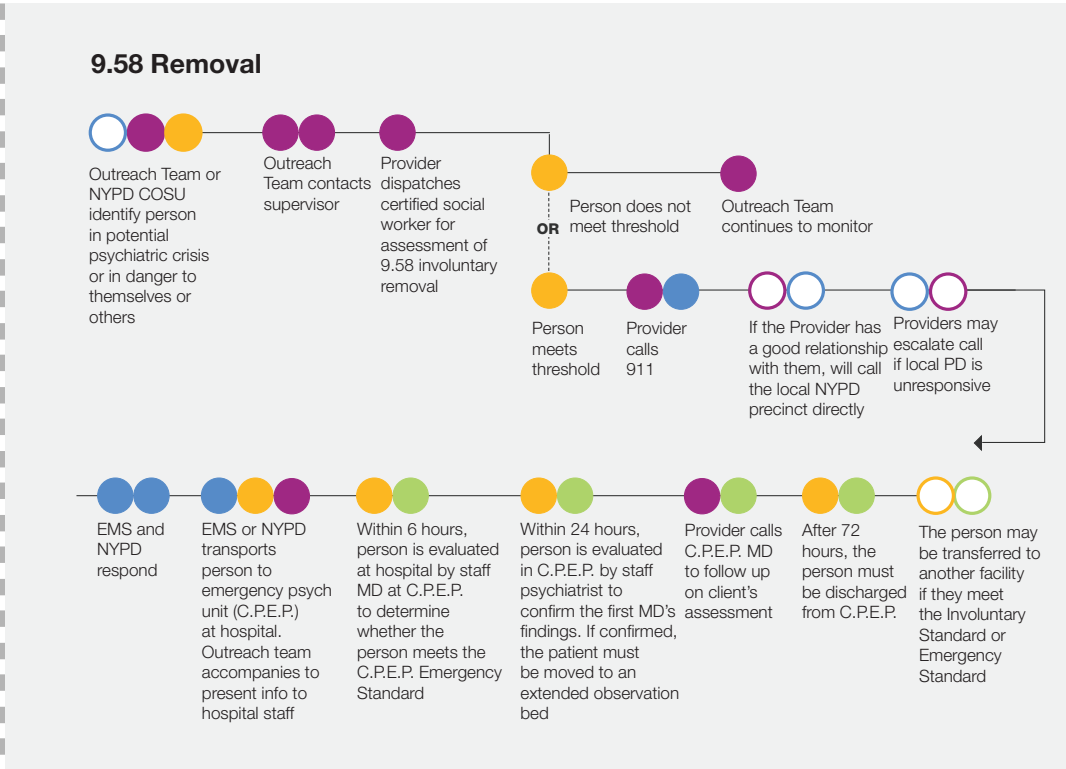
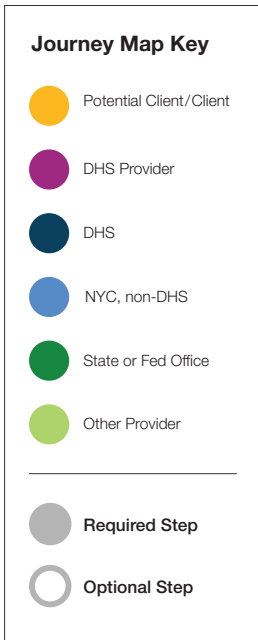
When an individual is having a medical emergency, Providers immediately call 911. Individuals may remain hospitalized for days or months, requiring ongoing advocacy work and discharge planning.



Person is a Danger to Themselves or Others and in Need of an Involuntary Removal

HOURS

The New York State Mental Hygiene Law allows for individuals to be involuntarily removed and taken to a psychiatric emergency facility. Most commonly used are 9.58 removals, which can be initiated by Outreach Teams or the NYPD and approved by a certified social worker. 9.37 removals can be initiated by psychiatrists in order to have an individual assessed at a mental health facility. Providers report that removals by a psychiatrist tend to be smoother because they are coordinated “doctor to doctor.” Both types of removals are preplanned and targeted toward individuals who are at-risk, especially in extreme weather.



Stories from the Street

On a frigid morning, a middle-aged man, who appeared much older than his actual age, was found bundled in a drafty subway stairwell and kindly refused services from the Outreach Provider. Although he had severe mental illness, there was not enough to qualify him for a 9.58 removal. The Outreach Team leader decided to issue a baseline report to their clinical team who then has 24 hours to return to the man to conduct a full assessment for a 9.58 removal.

Person is a Danger to Themselves or Others and in Need of an Involuntary Removal (continued)

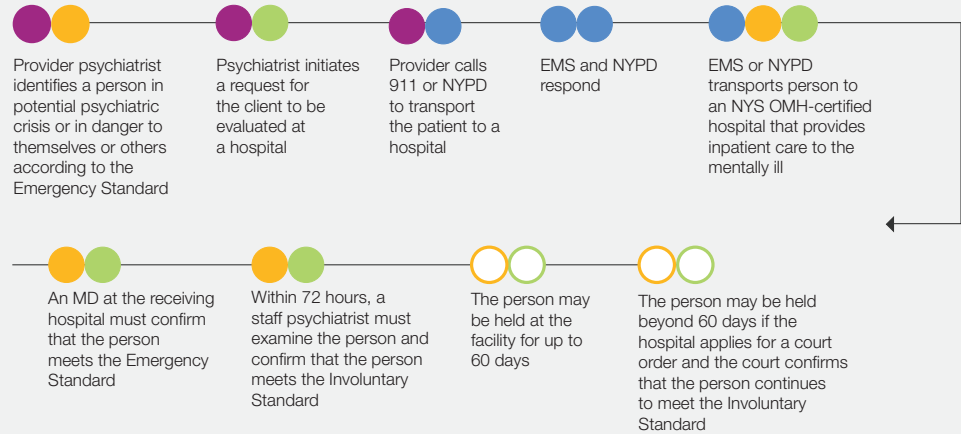
Time

When an Outreach Team believes a 9.58 is needed, it usually happens very quickly. However, these removals are usually pre-planned and coordinated with the appropriate service providers.

Tools and Resources

Make calls from shift phone or personal phone.

9.37 Removal



Time

When a psychiatrist believes a 9.37 is needed, it usually happens very quickly. However, these removals are usually pre-planned and coordinated with the appropriate service providers.

Tools and Resources

Make calls from shift phone or personal phone.

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

DHS reports that EMS responders will sometimes determine that referred individuals do not meet the threshold for 9.58 removal. In some cases, the person may not be in crisis in the moment, but the Provider has observed a recent deterioration of their physical or mental state. If the person stays on street, they risk further decline and danger, but Providers report that medical personnel making assessments on the street and in the hospital can disregard the social worker’s evaluation of the client’s situation, even if the social worker has a longer-term context.

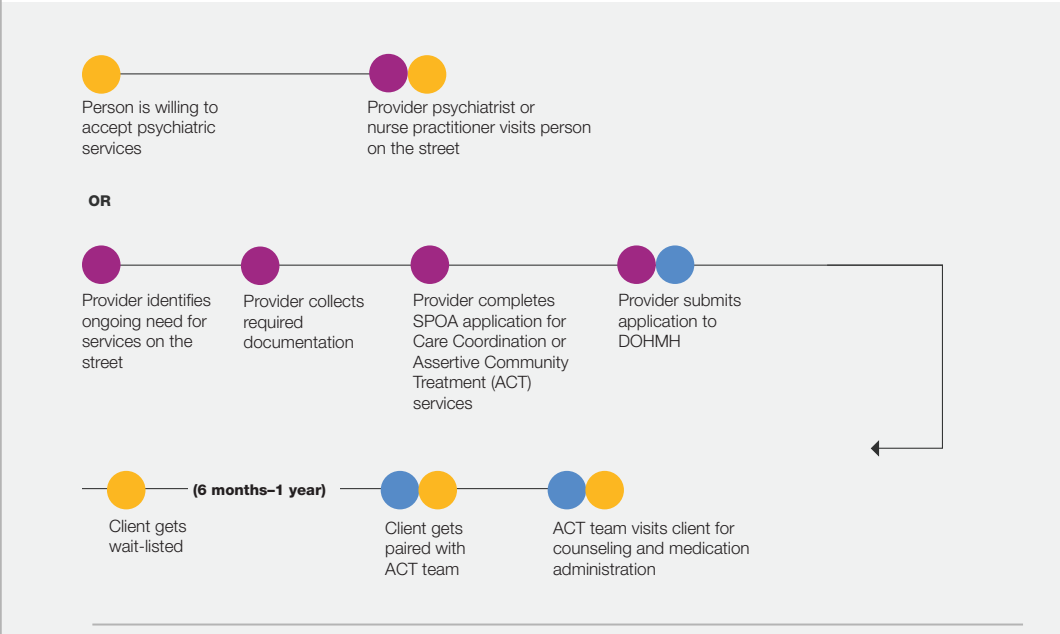
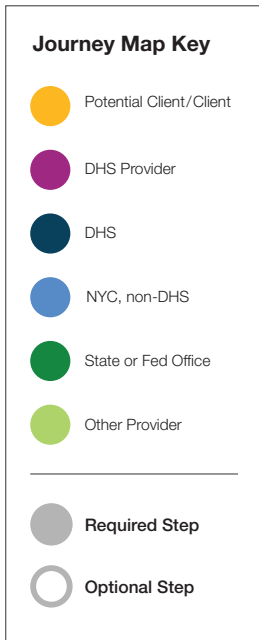
Additionally, EMS does not always transport the individual to the requested hospital, but rather the closest one. The workers say that many hospitals will quickly release them back to the street.

Person is a Danger to Themselves or Others and in Need of an Involuntary Removal (continued)

During a 9.58, NYPD helps enforce the authority to complete the involuntary removal. NYPD can also be a source of a referral for potential 9.58 removal. Providers report that establishing good working relationships with NYPD is beneficial to their work, especially in these situations. When Providers have a good working relationship with the local precinct, they also contact the precinct to let them know that a removal is going to happen. Providers have also expressed that recurring training and awareness for removals amongst NYPD, EMS, and medical staff would be beneficial. Providers and DHS have conducted trainings in the past at roll calls, precinct meetings, and the Police Academy, but as new officers are brought on, this knowledge is not passed on.

Person Needs Psychiatric Services on Street

ONE DAY-YEARS



Tools and Resources

- Psychiatric notes saved to digital and physical case files
- Documentation and status of SPOA application tracked in digital and physical case files
- Psychiatric evaluation tracked as part of the housing packet



Person Needs Psychiatric Services on Street continued)

The Providers are contractually required to have a psychiatrist on staff. Providers reported a wide variance in availability of psychiatric services. Three of the five Providers contract psychiatric services through The Center for Urban Community Services’ Janian (CUCS Janian) practice. Several Providers reported needing additional psychiatric services to serve their clients.

Current psychiatric staffing

BRC	Multiple nurse practitioners and psychiatrists
Breaking Ground	Two on-site psychiatrists, each in the office once/week (CUCS Janian), no nurse practitioners
BronxWorks	Psychiatrist in office 2x/week (CUCS Janian), no nurse practitioners
MOC	Psychiatrists in office 3x/week (CUCS Janian), no nurse practitioners
Project Hospitality	On-site psych for 4 hours per week

Psychiatrists work with case managers for on-street evaluations, document, and housing applications (see page 41). Some clients are resistant to meeting with a psychiatrist in the office, so some Outreach Teams take psychiatric staff with them while doing client visits. Providers report that on-street psychiatric services are usually performed in order to complete a psychiatric evaluation as a requirement for applying for subsidized housing (see page 72). Both psychiatrists and nurse practitioners can conduct the psychiatric evaluation. In addition, psychiatrists can do a specialized type of removal to a hospital known as a 9.37 (see page 30), which is coordinated with a doctor at the receiving facility.

Single Point of Access

Some clients have needs that can be served through supplementary programs available to New Yorkers, which Providers will apply for on their behalf. Single Point of Access (SPOA) is a program that connects people with serious mental illness to mental health services that can accommodate them. Assertive Community Treatment (ACT) is one of the services accessible through the SPOA program.

Person Needs Psychiatric Services on Street (continued)

Providers report that medication compliance can be particularly difficult for street homeless. The ACT program allows medical teams to administer medication on the street as well as provide clients with intensive case management. The Providers report that gathering all of the required documentation for the application used for ACT (SPOA) can be difficult and time consuming.

Providers report that, while the ACT services are beneficial, not many clients are eligible. The program requires a history of six psychiatric hospitalizations over the last two years. This information is not always known to the Provider facilitating the application, and even if the client was ill enough to require hospitalization, the client may not have received medical care at the appropriate time. In addition, the individual must:

- Have a diagnosed mental illness
- Be currently receiving Supplemental Security Income or Social Security Disability Income due to the diagnosis
- Have a documented impairment from mental illness
- Be reliant on psychiatric services

There is a long wait to receive ACT services. Manhattan is estimated at one year. Brooklyn and Queens are six months. Providers report that if a client is from Brooklyn or Queens, but is placed in transitional housing in Manhattan, that client will wait one year for ACT services.

If an individual does not qualify for ACT, an alternative is Care Coordination, which includes intensive case management, but only allows for medication monitoring instead of administration.

The following documentation is required to submit an SPOA application for ACT or Care Coordination services:


- Care Coordination/ACT Program Application cover sheet with signed consent
- Universal Referral Form (URF)
- CC/ACT Referral summary
- Psychosocial summary, no more than 6 months old
- Psychiatric evaluation, no more than 30 days old for inpatient referrals
- Medical exam results
- Discharge reports
- Authorization of release of URF application to the assigned Care Coordination or ACT program

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Section 4

Moving onto Caseload

Chronicity Thresholds

- 
- **Gathering More Information About an Individual and Assessing Eligibility for Services**
 - **Case Notes are Transferred into Databases and Physical Case Files**
 - **Case Manager Conducts Psychosocial Interview with Client**
 - **Case Manager Identifies Transitional or Permanent Housing for Client**

Shelter

Safe Haven Requirements

Resistance to Transitional Housing

Transitional Bed Availability Notification

As of May 2016, Providers include all homeless individuals encountered three or more times, or who have been determined to be homeless after the first or second encounter as HOME-STAT clients, regardless of chronicity, and assign a case manager. Some Providers utilize case managers for initial outreach and others later transition to case managers from outreach workers.

The relationship between the client and case manager is a critical component in the journey to securing permanent housing. For clients who accept services, the next steps often include an individual coming in off the street and to placement in transitional housing like a Safe Haven or stabilization bed. However, some clients continue to live on the street during this time.

Chronicity Thresholds (prior to May 2016)

Under program practices prior to May 2016, most Providers would need to verify chronicity before they moved a client onto caseload and assigned a case manager. These guidelines are provided here for reference.

Chronicity Thresholds by Provider

BRC	Any homeless individuals on the subway are immediately moved to caseload unless they have only been encountered once and never seen again.
Breaking Ground	Verified either by a third party or the Outreach Team to have lived on the street for nine months out of last two years or observed bedding down outside.
BronxWorks	Living on the street for nine months out of last two years.
MOC	Five sightings bedded down in three weeks or multiple engagements with the Outreach Team, and living on the street for nine months out of last two years.
Project Hospitality	Living on the street for nine months out of last two years.



Stories from the Street

The Outreach Team woke a man sleeping in a subway car who wanted to accept services. The man seemed to know the MTA employee on duty and they exchanged greetings. The Outreach Team asked the MTA employee if they could vouch for the man to help prove his homelessness, the employee refused to acknowledge them and the man after that.

Stories from the Street

The Outreach Team spotted an elderly woman that they encounter frequently but she refuses to engage. She is typically dressed in the same bathrobe and hat, and hauls several bags on the subway. As soon as she notices the Outreach Team, she diverts by exiting onto the platform, facing away from the team, and returning to a subway car once they are at a distance.

Gathering More Information About an Individual and Assessing Eligibility for Services

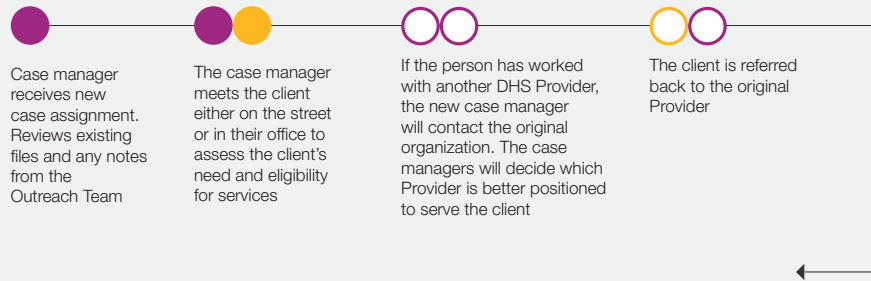
VARIES

Clients may be hesitant to share any information the first time they meet the case manager, which can happen on the street or for willing clients, in the Provider's office. One case manager reported that the first office meeting might just involve offering the client a cup of coffee and sitting with them until they are done. Other clients will share any information as the case manager requests. The process for information gathering and assessing the client's eligibility for services and transitional housing placement can happen in any order.

Providers obtain more information from forms and surveys:

BRC	Fact sheet (completed by Outreach Team), contact form (if the client has not given a name), and baseline evaluation form
Breaking Ground	Case management consent form and survey
BronxWorks	Basic Identification Sheet (BID) and mental health and safety assessment
MOC	Client info sheet
Project Hospitality	Screening and intake survey

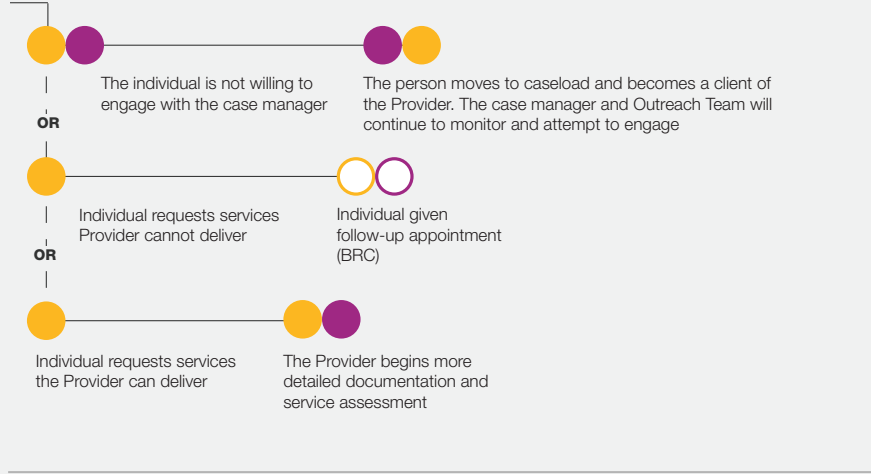
Gathering More Information About an Individual and Assessing Eligibility for Services (continued)



Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step



Tools and Resources

- Many clients have a mobile phone that case managers can call to get in touch
- CARES and Provider databases are referenced for any existing client information

Case Notes are Transferred into Databases and Physical Case Files

ONGOING



Time

The case manager will continue to update the client's case file after every meeting or new development.

Tools and Resources

Providers store case files in different data systems:

- BG: CDB, CARES, Awards & shared drive
- PH: Awards and CARES
- BRC: Awards and CARES
- BW: CARES
- MOC: MOCapp, CARES & shared drive

Case Manager Conducts Psychosocial Interview with Client

ONE DAY–WEEKS

The psychosocial interview is a key source of information that the case manager will need to guide the client through the permanent housing application process.

The psychosocial interview includes:

- Identifying information
- Sources of income
- Social, education, work, legal, and military history
- Homeless and housing history and current situation
- Psychiatric, substance abuse, and medical history
- Goals to obtain housing
- Summary and recommendations

The psychosocial interview is long and demands the client to share significant personal information and history. This survey acts as another form of trust-building between the case manager and their client.

Providers report that while they all use the same questions for the psychosocial, each Provider uses their own forms to document the evaluation. All questions for the psychosocial are based on the information required by HRA 2010e form. (See page 71.)

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

Required Step

Optional Step

Case Manager Conducts Psychosocial Interview with Client (continued)



Case manager gathers information from client that will be required for future housing application

Tools and Resources

- Psychosocial documentation is saved to digital and physical case file
- Psychosocial documentation is tracked as part of housing packet



Case Manager Identifies Transitional or Permanent Housing for Client

ONE DAY–MONTHS

While the end goal for the Outreach Providers is to permanently house clients, they also attempt to get clients off the street and in transitional housing until they are matched with a permanent home. Providers noted that not all clients will go into transitional housing before getting permanent placement, but many will require a transitional placement to achieve enough stability to be ready for permanent housing. All teams have a prioritization process, which sometimes includes a vulnerability index, to determine how clients get attached to transitional units.

Options for transitional housing include:

- Safe Havens** Single, double, and some dormitory-style rooms with beds, some Safe Havens are run by DHS-contracted Outreach Providers.
- Stabilization beds** Provider-run rented rooms, usually without on-site services.
- Drop-in centers** Provider-run 24-hour centers with chairs and shower facilities.
- Respite beds** Outside organization-monitored beds accessed through a drop-in center. Night time only.
- Opening Doors** Outside organization-monitored beds accessed directly by the Outreach Teams.
- DHS shelters** City and Provider-run communal beds with shared facilities.



“I’m so tired.”

—Client on waiting list for transitional bed

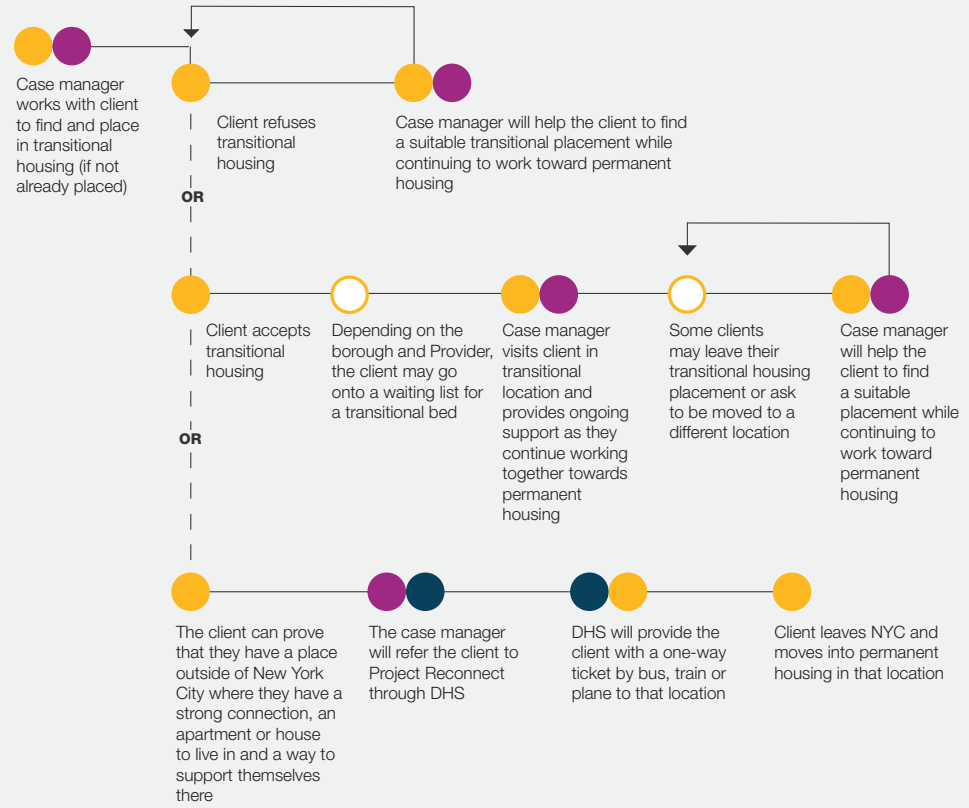
Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Case Manager Identifies Transitional or Permanent Housing for Client (continued)

There is wide variance in transitional housing availability by borough and client need.



Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

- Tools and Resources**
- Long-Term Stayer Letter
 - Proof of homelessness



“If you’re late by a minute, you’ll lose your bed, your belongings will get stolen, and you have to go through the process again. Discouraged me from the shelter — if I’m off by a couple of minutes, I’d lose my bed. They’d pop the lock and trash everything. That’s why you see many homeless carry all their possessions. Who wants to keep starting over?”

—Permanently housed client

Stories from the Street

A man found sleeping in the early morning hours at a subway station was thankful to the Outreach Team for waking him. Although he is currently placed in a single room occupancy shelter, he fell asleep at the station because he had missed their curfew. In addition, the man feared being late for his upcoming morning appointment at the nearby HRA Center.

Shelter

For clients who have previously been placed in shelter, Providers can only place someone in other transitional housing if they have been out of the shelter for six or more months. If less than six months, the Provider can only refer the individual back to their assigned shelter. This policy was changed in the past year; it used to be a one year requirement. DHS can change shelter assignment on a case-by-case basis, especially if resistance to shelter is keeping someone on the street. Shelters require individuals to sign an Independent Living Plan, which serves almost like a contract with the shelter for the six months. Many individuals are resistant to shelter due to the six month requirement, and Providers often prefer alternatives to shelter due to limited supportive services.

Safe Haven Requirements

In order to be placed in a Safe Haven, the client must have proof of homelessness. This may be a letter from an institution such as a soup kitchen, MTA, other Providers, etc. Providers may also compile evidence from multiple sources, including “unknowns” tracked as contacts by Outreach Teams that match that person’s description. Proving homelessness can be an obstacle to getting a client into transitional housing. There are some exceptions made for high priority and individual clients. Once placed in a Safe Haven, the client receives a Long-Term Stayer Letter, which serves as a proof of chronic homelessness. This documentation prioritizes the client for certain kinds of HUD-funded permanent housing, including Section 8 Shelter Plus Care, Section 8 Moderate Rehabilitation SRO units and Supportive Housing.

DHS allocates the number of Safe Haven beds available to each Provider, and the Providers determine which clients are placed where. While many of the Outreach Providers also manage Safe Havens, the client will not necessarily be placed in a Safe Haven that is connected to an Outreach Provider. In addition to the five DHS-contracted Outreach Providers, the organizations Volunteers of America, Urban Pathways and Communal Life also run Safe Havens in New York City.

Resistance to Transitional Housing

Some clients will continue to sleep outside even after being placed in transitional housing. Reasons for this can include:

- Unhappy with transitional bed location, including distance from required programs like substance abuse treatment
- Prefer to be near people they know

Resistance to Transitional Housing (continued)

- Resist separation from spouse or pet
- More comfortable sleeping outside
- Still transitioning to being indoors

Some clients will change transitional housing placements in order to be in a more suitable location or care setting. Other clients will leave transitional housing because of rule breaking or a lack of appropriate support at the current placement. In all situations, the case manager's primary goal is to help the client find permanent housing.

Transitional Bed Availability Notification

Safe Havens and Outreach Teams communicate transitional bed availability. Safe Havens call Providers when they have an opening for that team, and teams may proactively check in with the Safe Havens. DHS may get involved if it appears that a bed has been vacant for more than 72 hours and will inquire who is assigned to it and why it is unoccupied. It can be vacant for a number of reasons including:


- Held for a client who is in a hospital or substance abuse treatment program
- Being treated by an exterminator
- Outreach Team requiring more time to get a vulnerable client into the bed

The Manhattan Outreach Consortium (MOC) shared a specific example of a system-driven notification process. MOC teams are notified when transitional beds are available through the C-SPOA (Single Point of Access) notification system. The transitional provider enters a vacancy into the C-SPOA. MOC then uses its vulnerability index to prioritize clients for placement, but can advocate for other clients who may be high-need or an ideal fit. Once MOC says they would like to place a client, the program has 72 hours to fill the bed.

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Section 5

Gathering Vital Documents

- 
- **Getting a Social Security Card**
 - **Getting a Replacement Benefit Card**
 - **Getting a Birth Certificate**
 - **Getting a State ID**
 - **Getting an IDNYC**
 - **Getting Proof of Military Service**
 - **Applying for or Replacing a Permanent Resident Card**
 - **Applying for or Replacing a Naturalization Certificate**
 - **Securing an Official Name Change**

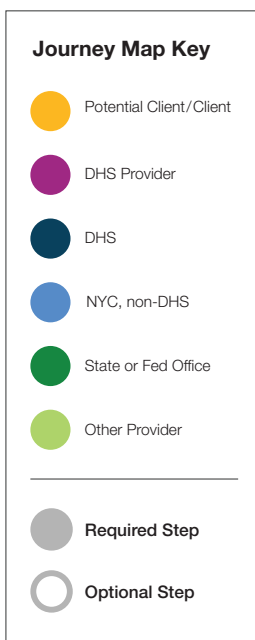
To be considered for permanent housing, a client will need proof of birth and citizenship, as well as and photo identification. Many clients are missing some or all of their vital documents, which makes it difficult to gather the others. Each client has a unique set of document needs and the case managers work to identify which documents will be most viable to attain.

Depending on the client’s situation, the case manager may receive mailed documents at their office on behalf of the client. In other cases, the client may use the address of a friend, family member, or another service Provider. Some clients will use a General Post Office (GPO) address to receive mail, although Providers do not recommend it.

Getting a Social Security Card

ONE–TWELVE WEEKS FROM SUBMISSION

Most Providers mentioned that the Social Security Office will work with them to get a client their Social Security Card. With this card, the case manager can begin to apply for other documents like a birth certificate. Sometimes clients forget their Social Ssecurity Number or their mother’s maiden name. Without these details, applying for a Social Security Card becomes difficult.





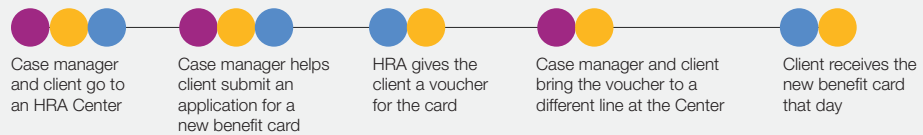
Getting a Replacement Benefit Card

ONE DAY

If a client is already receiving HRA benefits, the Provider may try to get them a replacement benefit card. This card could serve as an ID for the client (though not a photo ID) and be used to apply for the client’s additional documents. Previous versions of the benefit card included a photo and could be used as photo ID.

Replacement benefit cards can be issued in person at either of HRA’s two CBIC (Common Benefit Identification Card) locations, also known as their over-the-counter sites. These sites are housed within the HRA Centers, one in Manhattan and the other in Brooklyn. Case managers can also call HRA’s information line to receive a new card by mail to the address on file, but report often getting disconnected because the client is undomiciled.

Providers report that getting the clients to go into the HRA Center can be very challenging. Going through security and waiting in multiple lines is difficult for clients who may be mentally or physically frail. In addition, Providers report that clients feel “bounced from office to office” and may not be willing to travel to the HRA Center.



Tools and Resources

- Application forms
- HRA voucher
- Copy of benefit card saved to digital and physical case file

Journey Map Key

- Potential Client/Client
 - DHS Provider
 - DHS
 - NYC, non-DHS
 - State or Fed Office
 - Other Provider
-
- Required Step
 - Optional Step



Getting a Birth Certificate

VARIABLES BY STATE

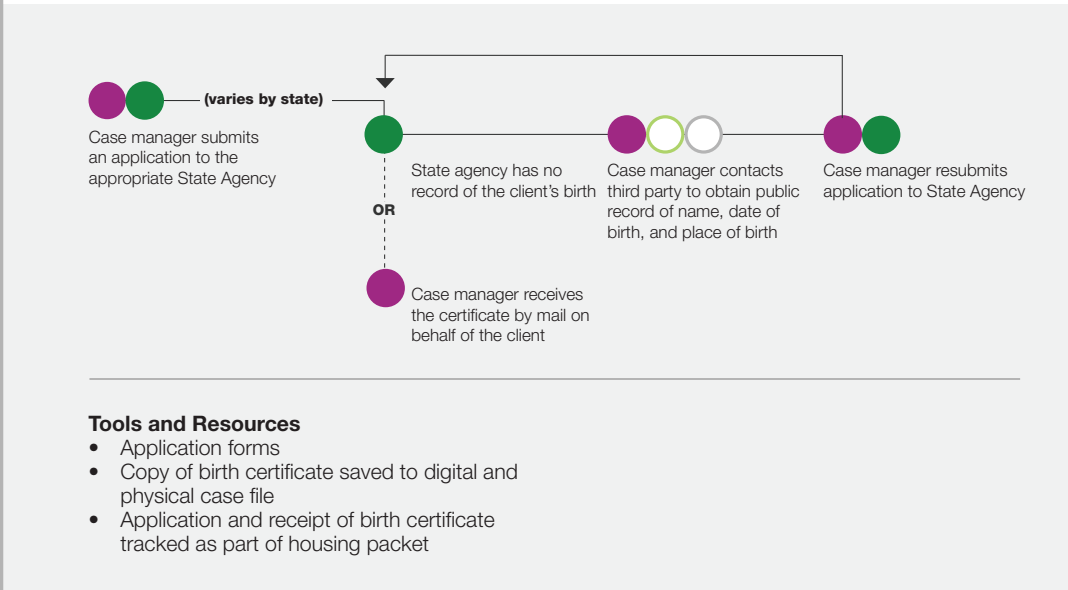
The case manager can apply for a birth certificate using the Social Security Card. Clients may not remember the name of the place where they were born or even their birth date, which makes it difficult for Providers to know where to start. All Providers reported that if the client is not from New York State, getting a birth certificate can cause significant delays in the process.

For older clients, birth certificates may be inaccurate or in unusual formats (e.g., handwritten), which can make it difficult for Providers to use the certificate to gather other documentation.

Getting a Birth Certificate (continued)

For clients who were born out of the country or had home births, there may be no record at all. In cases where the state agency has no record of the client’s birth, the case managers will try to obtain early school, census, or hospital records in order to establish proof of name, date of birth, and place of birth for the client.

Providers mentioned that client’s vital documents can sometimes be found in the CARES case file, but the system is not a reliable source of client documentation.



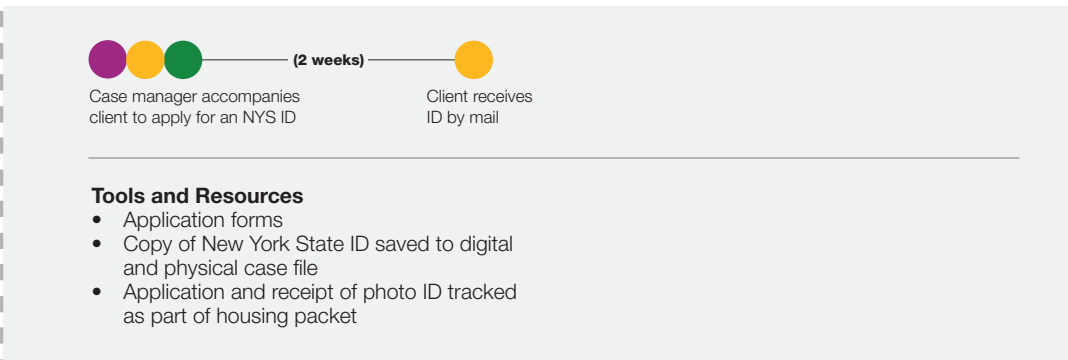
Tools and Resources

- Application forms
- Copy of birth certificate saved to digital and physical case file
- Application and receipt of birth certificate tracked as part of housing packet

Getting a State ID

TWO WEEKS FROM APPLICATION

The case manager and client can apply for a State ID using the Social Security Card and birth certificate. Getting a photo ID is a crucial step in meeting the requirements to apply for housing. All Providers mentioned that waiting in line at the Department of Motor Vehicles can be stressful for clients.



Tools and Resources

- Application forms
- Copy of New York State ID saved to digital and physical case file
- Application and receipt of photo ID tracked as part of housing packet

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

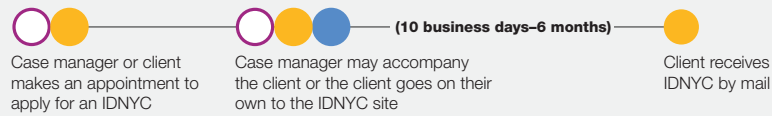
“NYC ID is tough, because you need a photo ID to get one.”
— Provider

Getting an IDNYC

TEN BUSINESS DAYS–SIX MONTHS FROM SUBMISSION

Many clients do not have the photo ID required for IDNYC and no Provider mentioned the IDNYC as a first choice for getting a photo ID for a client. However, one case manager offered to accompany a client to apply for an IDNYC so that he could have a photo ID to keep on him, while she kept his green card in his file. She also shared that she had another client apply for an IDNYC on her own.

Providers report that the advance appointment required for IDNYC can pose a serious hurdle for the client.



Time

One Provider reported a six month wait for the card. NYC.gov quotes ten to fourteen business days from submission.

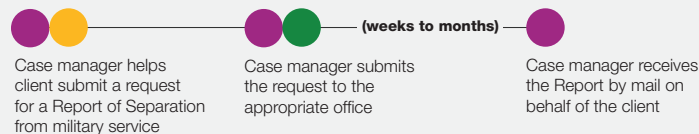
Tools and Resources

- Application forms
- Copy of IDNYC saved to digital and physical case file
- Application and receipt of photo ID tracked as part of housing packet

Getting Proof of Military Service

WEEKS TO MONTHS FROM APPLICATION

A Report of Separation is used to verify military service for benefits and can allow eligible clients access to specialized services for Veterans. DHS reports that, if a client has their Social Security Number, the Report of Separation can be easily obtained. However, Providers have faced unique challenges obtaining proof of military service, including one case where a Veteran was de-identified as a part of his service, making his vital documents nearly impossible to obtain.



Tools and Resources

Copy of Report of Separation saved to digital and physical case file

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Getting Proof of Military Service (continued)

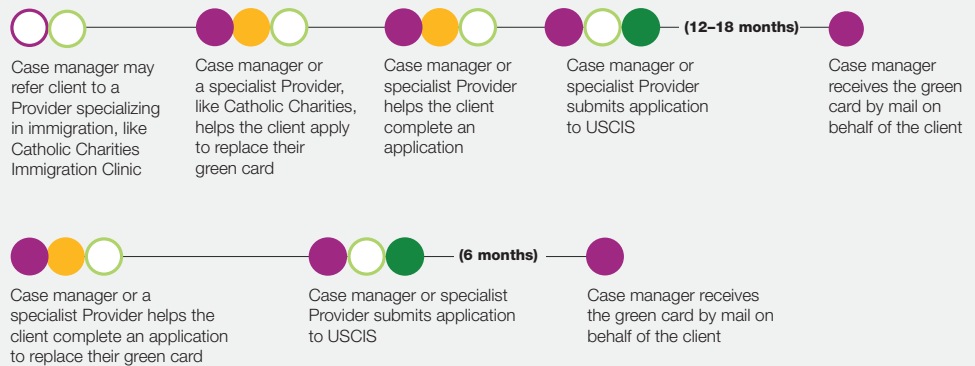
The following forms are required to request a military service record:

- Standard Form 180: Request Pertaining to Military Records
- DD Form 214: Report of Separation

Applying for or Replacing a Permanent Resident Card

12-18 MONTHS FROM SUBMISSION FOR ELIGIBLE CLIENTS

Providers help some clients who are not United States citizens obtain authorization to live and work in the United States on a permanent basis. Many Providers rely on other Providers, such as Catholic Charities’ legal services, in order to help clients with immigration-related needs. In some cases, it is possible to get a fee waiver for green cards.



Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Tools and Resources

- Permanent Resident Card held by case manager on behalf of client
- Copy of card saved to digital and physical case file
- Application and receipt of card tracked as part of housing packet

The following forms are required to apply for a green card:

- Form I-485: Application to Register
- Permanent Residence or Adjust Status
- \$0–\$1,070 fee

Applying for or Replacing a Permanent Resident Card (continued)

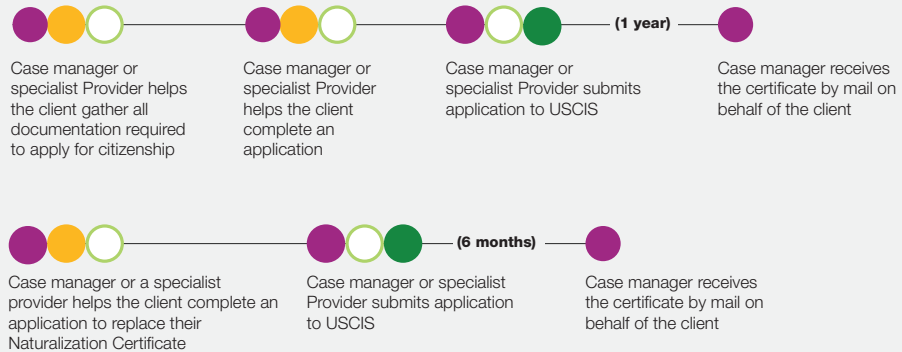
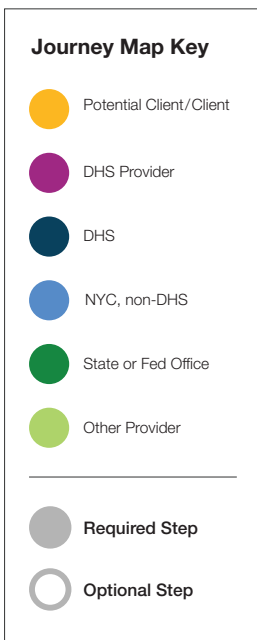
- An original official copy of each of the client’s arrest, sentencing, probation, or parole records; and/or any court orders removing such items from the client’s record, if applicable
- Foreign birth certificate
- Copy of passport page with non-immigrant visa
- Form I-693: Report of Medical Examination and Vaccination Record, if applicable
- Form G-325A: Biographic Information Sheet
- Evidence of eligibility
- Evidence of public assistance received in the US

The following forms are required to replace a green card:

- Form I-90: Application to Replace
- Permanent Resident Card
- \$365 filing fee
- \$85 biometric services fee, if applicable

Applying for or Replacing a Naturalization Certificate

AT LEAST ONE YEAR FROM SUBMISSION FOR ELIGIBLE CLIENTS



Tools and Resources

- Copy of Naturalization Certificate saved to digital and physical case file
- Application and receipt of Certificate tracked as part of housing packet

Applying for or Replacing a Naturalization Certificate (continued)

The following forms are required to apply for a Naturalization Certificate:

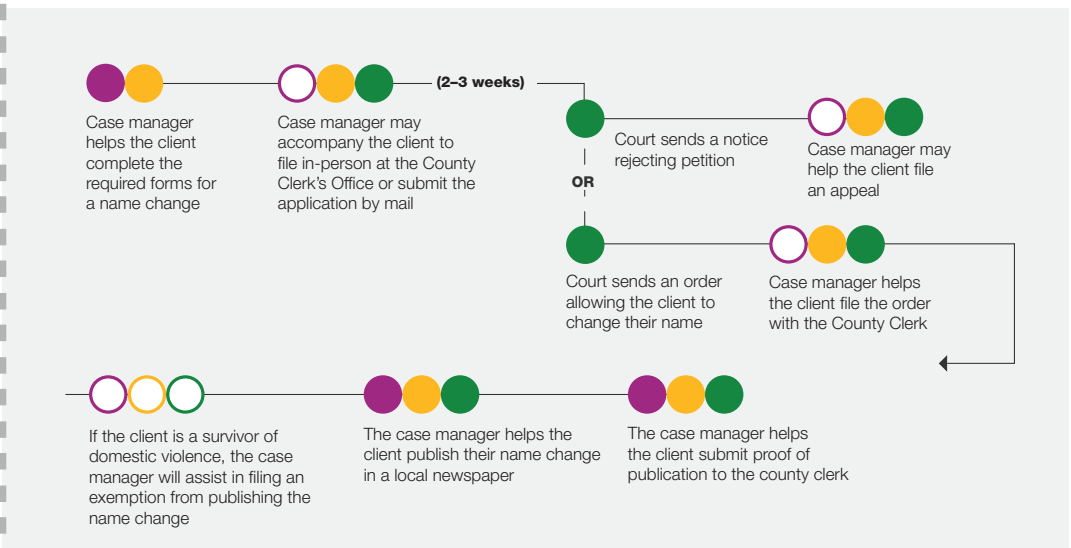
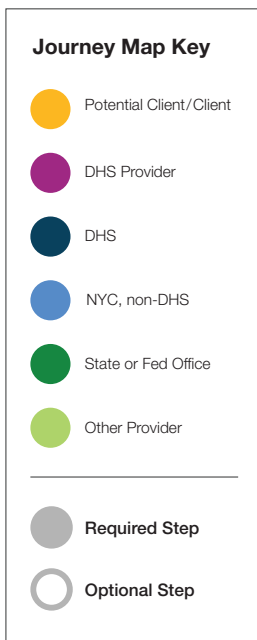
- Permanent Resident Card
- Form N-400: Application for Naturalization
- Nonrefundable \$680 fee
- Evidence of financial support of dependents, if applicable
- Proof of military service, if applicable
- An original official copy of the each of the client’s arrest, sentencing, probation, or parole records; and/or any court orders removing such items from the client’s record, if applicable
- Form N-648: Medical Certification for Disability Exceptions, no more than six months old, if applicable
- Any correspondence with the IRS regarding failure to file taxes, if applicable
- “Status Information Letter” from the Selective Service, if applicable
- Form I-912: Request for Fee Waiver

The following forms are required to replace a Naturalization Certificate:

- Form N-565: Application for Replacement Naturalization Citizenship Document
- \$345 filing fee

Securing an Official Name Change UP TO SIX MONTHS

Sometimes clients will want to change their names or have been known by a name that is not the name on their official documentation. The case managers can help them through the process and, often times, cannot get the other required documents listed above until the name change is official.



Securing an Official Name Change (continued)

Tools and Resources

Copy of court order or rejection notice saved to digital and physical case file

The following forms are required to secure an official name change:

- Name change petition
- Name change order
- Request for Judicial Intervention
- Index Number Application
- \$305 filing fee, or Affidavit in Support of Application to Proceed as a Poor Person
- Affidavit of Publication, if applicable

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Section 6

Applying for Public Assistance



Applying for Public Assistance

HRA Centers

WeCARE

Homebound Program

Sanctions

Recertification

Medicaid

To be eligible for permanent housing, a client must have an income, usually in the form of Public Assistance or Social Security. Case managers work to secure these supports for a client, but enrolling homeless individuals in benefits programs can be a difficult process due to traveling to appointments and meeting all requirements.

Applying for Public Assistance

45 DAYS FROM INITIAL APPLICATION

Public Assistance, SNAP, and Medicaid are available from the Human Resources Administration (HRA). Public Assistance is needed for ongoing expenses and often to fund their eventual housing placement. HRA also refers to Public Assistance as Cash Assistance. If needed, emergency SNAP benefits are available for clients who are screened and deemed eligible. HRA will provide the client with a referral letter to visit one of the City's two CBIC (common benefit identification card) locations to obtain a benefits card and receive immediate SNAP assistance.

In an ideal case, the Public Assistance application process involves at least four appointments, though Providers cite a baseline of six due to needing to return with additional documents or information. In most cases, the case manager will accompany the client to all appointments during the benefits application process. Providers report that at every step, there is a risk that clients may be reluctant or unable to attend the appointment, which could require starting the process over again.

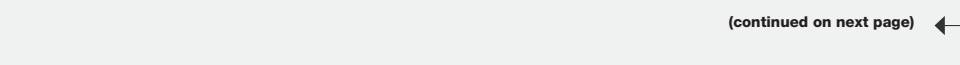
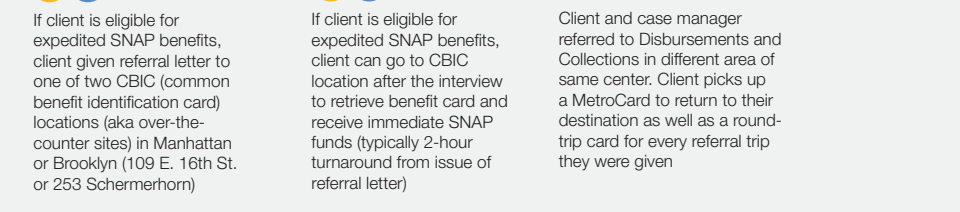
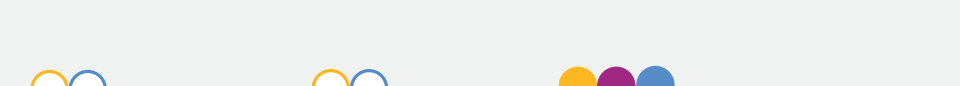
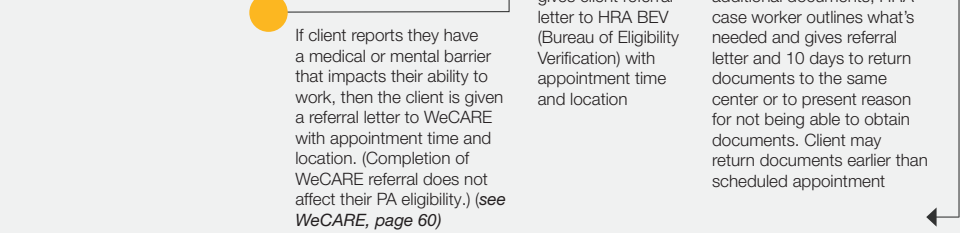
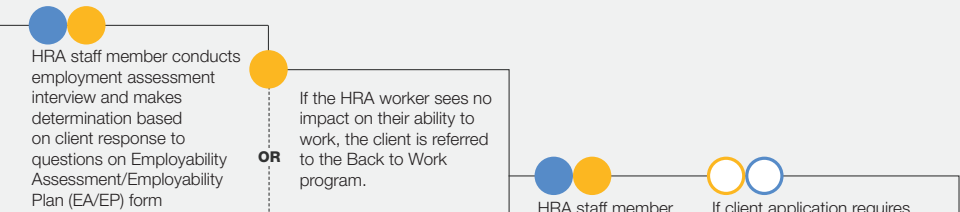
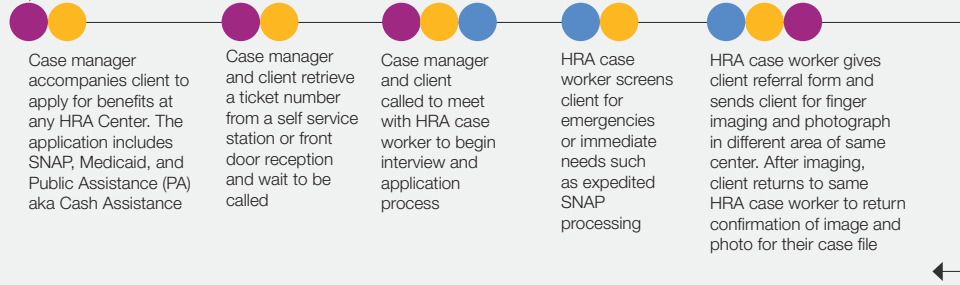
HRA will process the application and make a decision 25–30 days after initial submission. If documents are missing or referrals are incomplete, the client's application can be denied. Clients and case managers can apply for a fair hearing if they disagree with the cause for rejection. If the application is complete, benefits will be activated on or after 45 days, as mandated by the state of New York. Prior to the 45th day and if the application has been approved, HRA will mail the client two separate letters, one with their benefit card and the other with the card's pin number so they may begin accessing benefits as soon as they are activated.



**“In a perfect world,
Public Assistance
takes 45 days.”**

— Provider

Applying for Public Assistance (continued)



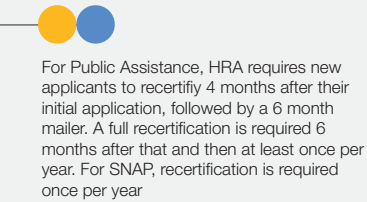
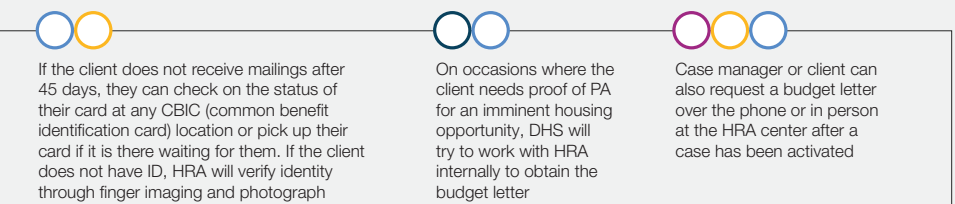
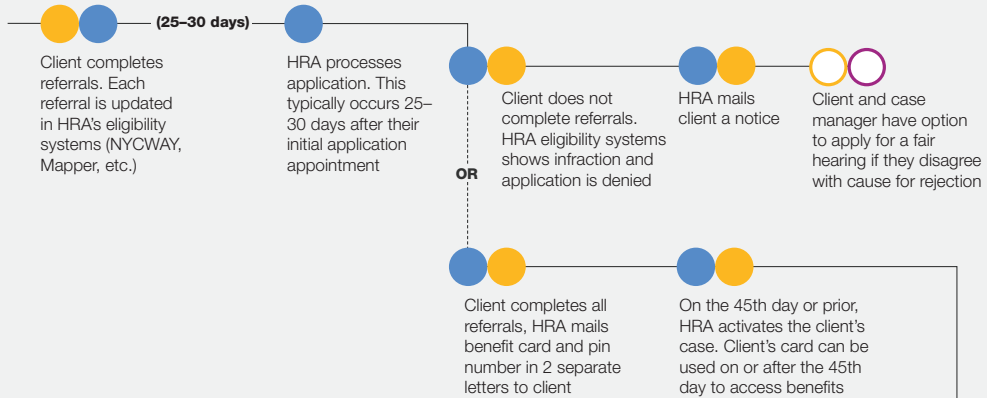
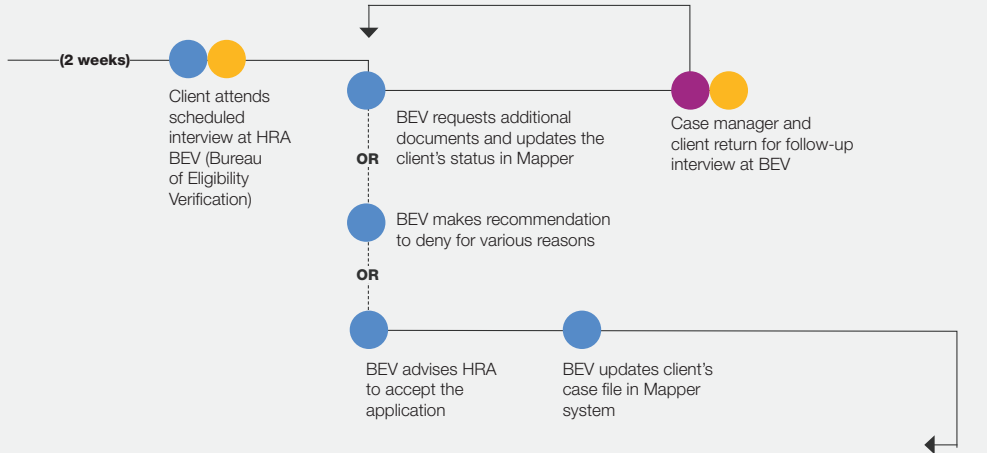
Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Applying for Public Assistance (continued)

BEV (continued)



Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Applying for Public Assistance (continued)

Providers report that for a client living in a Safe Haven, Public Assistance is \$45 per month compared to \$264 per month for clients living on the street. This disparity, coupled with program conditions, sometimes makes it difficult to convince clients to go through the effort of applying for and maintaining a public assistance case and also staying in transitional housing.

The following documents are required to apply for Public Assistance:

- Application forms
- Proof of identity
- Proof of age
- Proof of residence, if applicable
- Proof of citizenship or alien status (original)
- Proof of income, if any
- Documentation of medical expenses, if any
- Proof of health insurance, if any
- Social Security Card (not required for Cash Assistance)
- *For Homebound program only:* residency letter, support letter, and verification of homelessness

Although proof of identity is required, HRA reports that their threshold for proof is low. If a client does not possess an ID card, HRA reports that a client can confirm identity through their Social Security Number, if they know it. The client can also provide collateral contacts or notarized letters. For clients born in New York City, HRA can run a match with the Department of Health and Mental Hygiene's vital records to obtain a copy of their birth certificate.

If at any point a client cannot provide follow-up documents on time or at all, HRA can provide extensions if notified or assist the client in obtaining the required documents. According to HRA's Duty To Assist policy, all HRA staff are required to assist all clients in accessing public assistance at any point in their application or recertification, whenever possible. This may be in the form of:

- Finding birth certificates (for New York City and other locations)
- Obtaining information from collateral contacts
- Referring them to the Social Security Administration for proof of identity
- Data matching for employment verification

HRA Centers

Note: Independent process changes underway regarding HRA Center 37 requirements



“Any appointment is difficult if you don’t have a home.”

— Provider

In New York City, any individual can apply for public assistance at any of the City’s HRA Centers. All clients are guaranteed to be seen that day, regardless of arrival time. If a client cannot stay and wait to be seen, HRA will preserve their filing date for seven days. For homeless individuals, services have recently been centralized at Center 37 in Long Island City, with the intention of providing specialized homeless-related expertise. DHS and the Providers expressed frustration and complications with visiting Center 37 including:

- Clients and case managers routinely wait five to seven hours per appointment at the Center. This is particularly challenging for clients who are employed and take time off to go to the HRA Center. In addition, this wait time precludes case managers from working on any other cases that day. Breaks are also not allowed and food is prohibited.
- The single Center is far from where many clients and Providers are, especially the Bronx and Staten Island. Clients are often reluctant to leave the borough they are in. Providers report that convincing clients to come in only to experience long waits and unresponsive staff can damage the relationship between the case manager and client, and discourage the clients from moving forward with the permanent housing process.
- Clients and case managers bring all documentation with them to every appointment in instances where they need to provide proof that they made a previous visit or completed required documentation if HRA’s data systems are not updated by their staff. Returning multiple times was cited as a major obstacle in completing this process.
- The rules and processes are opaque and inconsistent. While their impression was that the Center’s staff were intended to be experts in assisting the homeless population, Providers described the experience as daunting and insensitive.
- Providers and DHS report that there is no protocol to address issues with HRA. Improving this protocol was a priority enhancement that was addressed in the summer of 2016.



WeCARE

As part of the application process, clients are interviewed and assessed for employment. If the HRA worker determines that the client is able to work, they are required to participate in the Back to Work program. If the client reports having a medical or psychological barrier to self-sufficiency, they are referred to WeCARE (Wellness Comprehensive Assessment Rehabilitation Employment) for a medical and mental health evaluation by a contracted service Provider. At their assigned WeCARE appointment, the client is seen by a physician and undergoes the following:

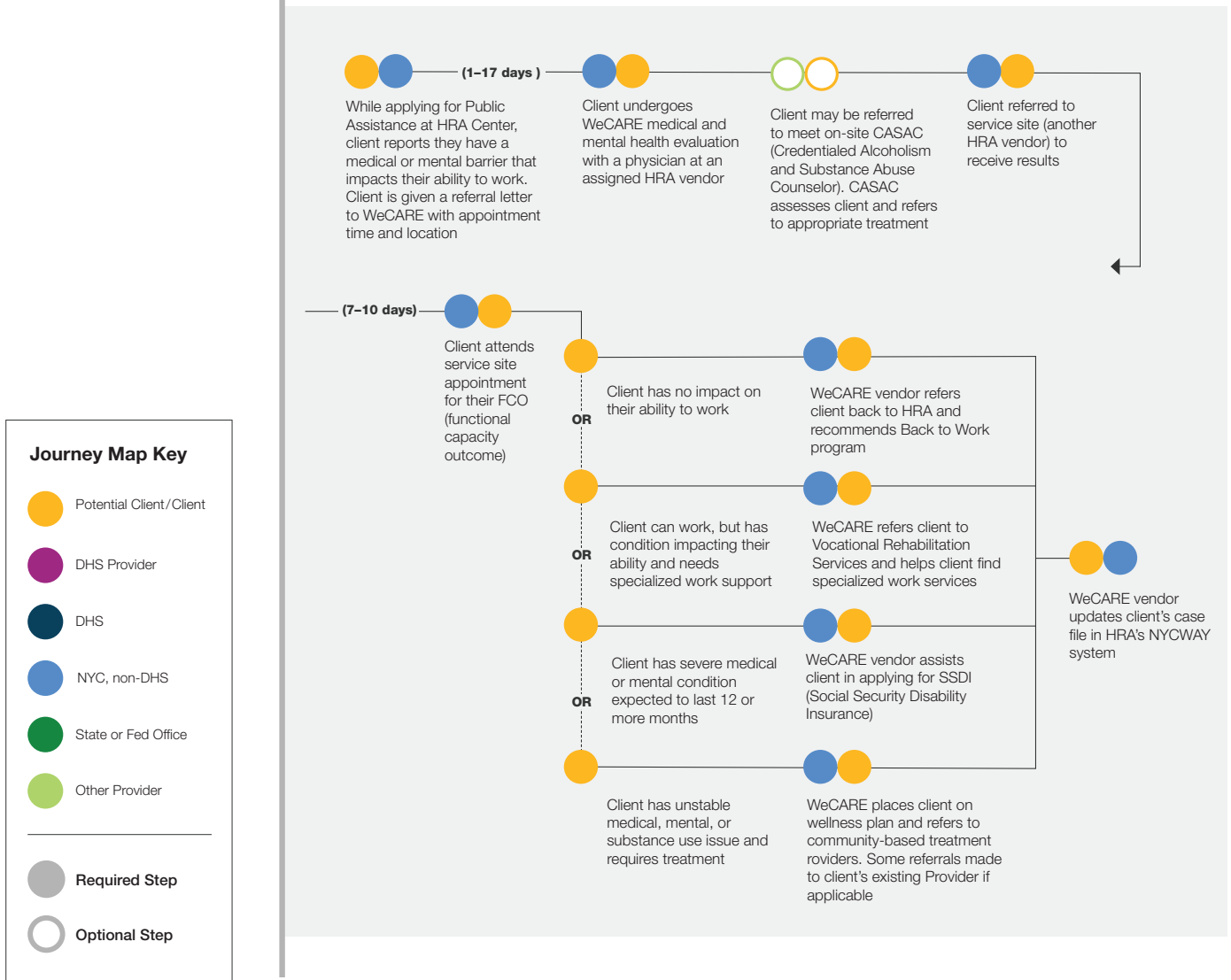
- A physical
- A psychosocial interview
- Urine and blood testing
- A psychiatric assessment by a psychiatrist, if needed
- Review of any medical documentation they provide the physician

After the examination, the physician will determine the client's functional capacity outcome (FCO). If the client has a medical or mental condition expected to last 12 or more months, WeCARE will assist the client in applying for Federal Disability Benefits (SSI/SSDI), including obtaining additional supporting medical documentation. If the client needs medical treatment to stabilize their condition, they will be placed on a Wellness Plan, which includes linking with appropriate treatment Providers, monitoring and facilitating compliance and progress in treatment, case management, and health education.

If the physician determines the client can engage in work-related activities, they are referred back to HRA for the Back to Work program, or if they can work but require specialized work support, to Vocational Rehabilitation Services that help clients find work that accommodates their condition, in addition to case management, medical treatment, health education, and job retention services.

Clients are given one to five days to respond to the physician's recommendation. If they are unable to respond in that time period, they are given an additional 11 days to followup and in rare cases may request even more time. WeCARE is not a determinant for Public Assistance eligibility.

WeCARE (continued)



Note: Business process changes underway for Homebound Program.

Homebound Program

All Providers reported that the Homebound program is the most effective for their clients. The Homebound program has no work or substance abuse treatment requirement and also provides field workers from HRA who can travel to the client to guide them through the application process and submit their information into HRA's case systems. Providers or their clients may request assistance from Homebound at any point in the process. HRA has recently made Homebound easier for homeless individuals to access through an improved DHS referral form. Providers must submit documentation of medical or mental limitations and a letter identifying the client.



“No clients should have to work every day before they have a home.”

— Provider

Homebound Program (continued)

Providers are developing good working relationships with staff from the program and report that they are knowledgeable and communicate pertinent information that has been helpful to their client's cases.

Once the benefits are active, the clients must adhere to the requirements of their Public Assistance. Clients who aren't on the Homebound program will have either work or substance abuse treatment requirements as a condition of their Public Assistance case. In some cases, Providers report that clients with ongoing substance abuse issues will be required to attend work programs. These programs require regular attendance and, for back to work programs, professional dress. Especially for clients who are still living on the street, meeting these standards is nearly impossible. If any component of the required program is missed, the case will be sanctioned and the client's Public Assistance income will be turned off.

Recertification

At least once per year, clients are required to recertify their benefits. If the client misses any of the recertification appointments, the case will be sanctioned and the client's Public Assistance income will be turned off.

Medicaid

In addition to Public Assistance, the client will also need active health insurance to be eligible for some types of housing. Clients are given 90 days to select a Medicaid plan. If a plan is not chosen, they are auto-enrolled in one with the option to change their plan within 30 days. Providers reported that while applying for Medicaid is straightforward, choosing the wrong plan can lead to obstacles in the future.

One Provider reported a case where a client was ready for addiction rehabilitation, but the constraints of their Medicaid meant that there were almost no facilities in New York where the client could receive treatment. According to HRA, there are some Medicaid health plans that include HRPs (health and recovery plans) that are specific to clients with mental health and substance abuse issues. These plans provide greater flexibility and access to clinics that serve the HRP network specifically. Providers report not being aware of these plans and are unclear if it is the responsibility of HRA workers to share this information when a client is asked to choose a plan.




“If someone chooses the wrong [Medicaid] plan, then it's almost impossible to get them care.”

— Provider

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Section 7

Securing an Income Other than Public Assistance

- 
- Applying for Supplemental Security Income or Social Security Disability Insurance
 - Documenting Veterans Benefits
 - Documenting Pension Benefits
 - Getting Proof of Income (for Employed Clients)
 - Documenting Informal Income

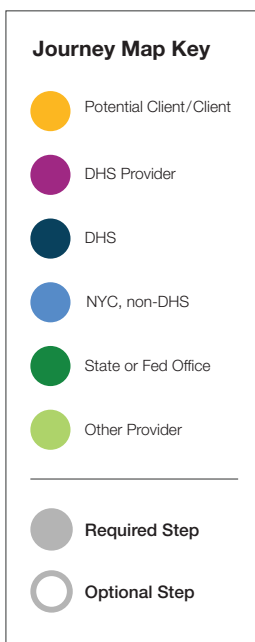
While Public Assistance is a common income to secure for the chronically street homeless, some may be eligible for Social Security or Veterans benefits, and others may be receiving employment income, informal income, or pension benefits.

Applying for Supplemental Security Income or Social Security Disability Insurance (SSI or SSDI)

SIX MONTHS–ONE YEAR FROM APPLICATION

Social Security is an option for many clients and the application process can only be started once vital documents are obtained. Providers report that some clients will refuse Public Assistance if they are in the process of appealing an SSI case, out of fear of having their SSI appeal rejected due to the new income.

A Provider also told a story of a woman who was receiving enough Social Security to pay for housing, but they were encountering issues in obtaining documents so she remained on the street.



Applying for SSI or SSDI (continued)

The following documentation is required to apply for SSI or SSDI:

- Application forms
- Social Security Card
- Birth certificate
- Photo ID
- Medical documentation



Documenting Veterans Benefits

Clients receiving VA benefits can submit those benefits as proof of income in their housing application.



Documenting Pension Benefits

Clients receiving pensions can submit those benefits as proof of income in their housing application.



Getting Proof of Income (for Employed Clients)

ONE DAY

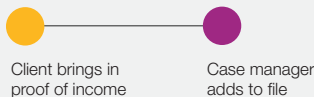
Some clients are employed. These clients can submit their earnings as proof of income in their housing application.

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

Required Step

Optional Step



Documenting Informal Income

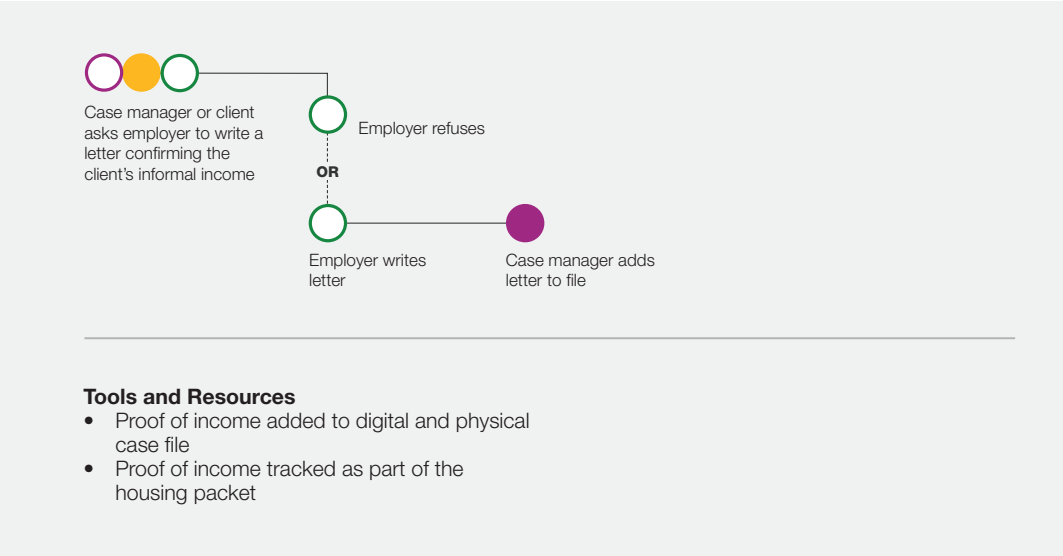
VARIES

DHS reported that documented informal income can be used to help a client qualify for certain programs. However, employers may be reluctant to provide a letter because of the tax or legal implications.

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step



Tools and Resources

- Proof of income added to digital and physical case file
- Proof of income tracked as part of the housing packet

Section 8

Applying for Permanent Housing

- Submitting an HRA 2010e Supportive Housing Referral
- Resubmitting an HRA 2010e Supportive Housing Referral
- Applying for General Population Housing
- Obtaining an HPD Section 8 Voucher
- Living in Communities (LINC) Rental Assistance Program
- HPD's Homeless Set Aside Units
- Waiting for Housing to Become Available

There are a range of housing types that clients may be eligible for including different levels of supportive housing, specialized placements for groups like veterans or people living with HIV/AIDS, or general affordable housing with a range of funding sources from Section 8 to the Living in Communities (LINC) Rental Assistance Program. To access most opportunities, the Provider must submit a housing packet to the Human Resources Administration (HRA) or Housing Preservation and Development (HPD) on the client's behalf.



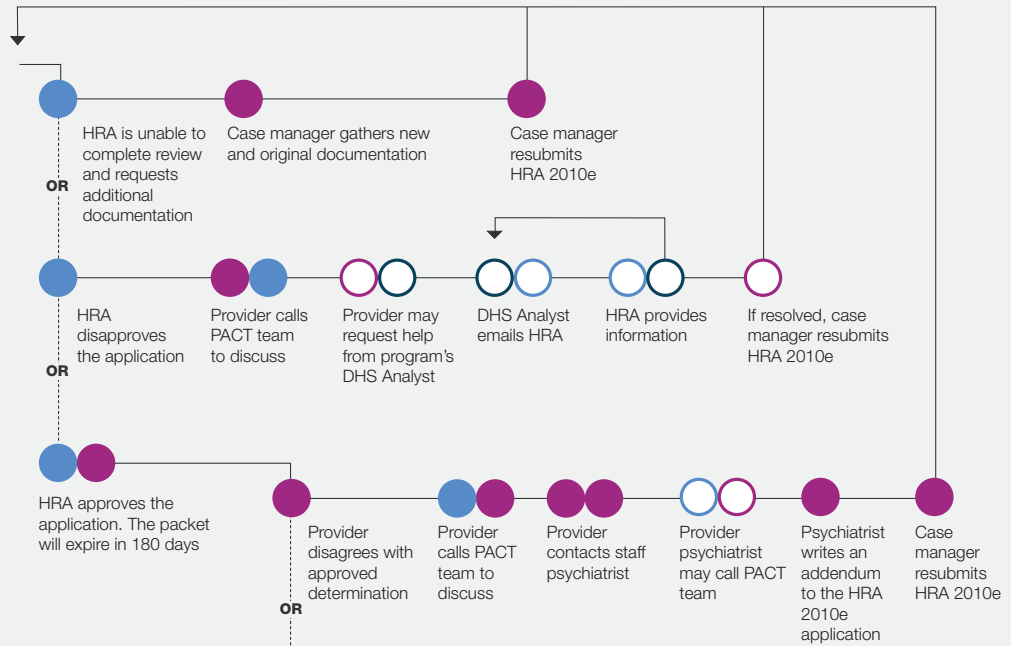
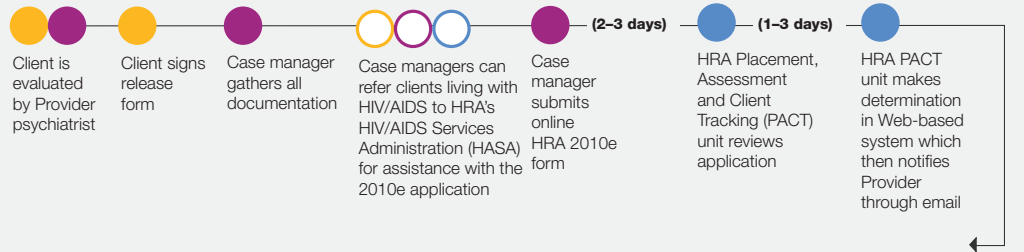
Submitting an HRA 2010e Supportive Housing Referral

ONE-SIX MONTHS

Providers report that 60–70% of their clients will require supportive services in their permanent placement. Many of these clients will apply for supportive housing through the HRA 2010e process. This provides access to permanent housing, coupled with varying levels of supportive services to help the client live independently.

(see journey map on next page)

Submitting an HRA 2010e Supportive Housing Referral (continued)



Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Client qualifies for general population housing. (see *General Population Housing on page 77.*)

OR

Client qualifies for supportive housing. The client may be eligible for one or more types of supportive housing:

- NY/NY I
- NY/NY II
 - Levels 1-2
 - Community care
- NY/NY III
 - Categories A-H

OR

Client qualifies for specialized housing through programs like HUD VASH (for Veterans) or HASA (for people living with HIV/AIDS)

Submitting an HRA 2010e Supportive Housing Referral (continued)

Tools and Resources

- Status of individual housing packet is noted in digital and physical case file
- Copy of HRA Approval Letter is added to digital and physical case file

The status of housing placements is reported to DHS on a daily to weekly basis.

An HRA 2010e Supportive Housing Application includes:

- 2010e application form
- Social Security Number
- Psychosocial evaluation, no more than six months old
- Psychiatric exam, no more than six months old
- Signed release form

Upon approval of the application, the HRA 2010e Supportive Housing Referral packet may include the following, depending on housing funding source:

- Cover letter
- Birth certificate or naturalization papers
- Photo ID
- Social Security Card
- Proof of active health insurance
- Award or Budget letter or proof of income from the last 30 days
- Physical Exam Results, no more than 1 year old
- Psychosocial evaluation, no more than 6 months old
- Psychiatric exam, no more than 6 months old
- Proof of homelessness
- Long-term shelter stay letter
- Signed release form

The HRA 2010e Supportive Housing Referral packets are reviewed by HRA's Office of Health and Mental Health Services/Placement, Assessment and Client Tracking Unit (OHMHS/PACT).

The psychiatric evaluation is used to inform the recommended level of care the client will need in their permanent housing placement. This level of care is a key factor in the types of housing for which a client can qualify. Providers mentioned that some clients are hesitant to meet with the staff psychiatrists. This can lead to some delay until the client is ready for the evaluation.

Many clients will require supportive services in order to remain in their permanent housing placement. For these clients, Providers will include a



“For any type of housing, the supply just doesn’t meet the demand.”

—Provider

Submitting an HRA 2010e Supportive Housing Referral (continued)

recommendation for placement into a supportive housing facility as part of the 2010e submission. Providers report that clients who require supportive services do not always receive that designation from HRA. HRA works closely with Providers to try to resolve issues and provide the most appropriate designation. Clients who need support to live independently but are ineligible for supportive housing face major challenges to remaining housed after placement.

Providers mentioned that the online HRA 2010e form requires them to repeat much of the information covered in the supporting documents. HRA requires this information to be in the digital format to allow reviewers to examine the applications quickly for a fast designation.

If any changes are requested, the online form must be refilled in its entirety and resubmitted. HRA has a “resubmit” function that copies over all information from the previous application, but it must be completed within 30 days.

Sometimes housing packets are disapproved or will “get stuck” in the HRA process and DHS Analysts will step in to help. Analysts mentioned that, while there are HRA liaisons at DHS, there is no specified protocol for contacting HRA about issues with housing packets. Holdups like this were cited as a major obstacle to clearing up any issues that might arise during processing. Both Providers and Analysts reported that reasons for disapproval by HRA can be unclear and difficult to follow up on.* HRA uses stock language for the 2010e designations and encourages Providers to best document the client’s conditions, without leading them on what to say to get approval.

The availability of types of housing is also a key consideration for Providers and clients when choosing types of housing. For instance, clients with a determinations for NY/NYIII Category E (active substance users) are unlikely to receive that kind of housing, because the supply in New York City is very low. Providers will either try to get the determination changed to Category A, (chronically homeless single adults who are diagnosed with a serious and persistent mental illness (SPMI)), or as mentally ill and chemically addicted (MICA), which has a higher supply of housing, or encourage those clients to go into general population housing, where they will not have all of the supports in place that they may need to live independently.

* Enhancements to the HRA 2010e have since been developed to address these issues.

Submitting an HRA 2010e Supportive Housing Referral (continued)

Providers reported that inappropriate determinations from the PACT team have recently become less of an obstacle, however they are reporting inconsistencies in determinations. They cited recent cases where clients had similar conditions but were given different housing designations, and PACT reviewers said there was not enough evidence for Category A.

The Providers are often unclear why this happens or how to plan for it. They emphasized the importance of training case managers and psychiatrists in how best to document a client’s condition in order to secure the most appropriate determination. HRA encourages Providers to attend the CUCS 2010e training and utilize the HRA technical training and technical support phone number for assistance.

Once a supportive housing application has been approved, the client receives an HRA Approval Letter, which includes the client’s housing eligibility information.

All Providers report the status of housing packets to DHS on a monthly basis. Movement of housing packets and placement into housing are critical goals for all of the programs. HRA tracks the availability of housing units and electronically reports out.

Resubmitting an HRA 2010e Supportive Housing Referral

EVERY 180 DAYS

HRA 2010e housing packages need to be updated and submitted every six months after the determination date. The main application must be updated, but the supporting documents can be a few months behind. DHS staff reported that most clients will have to submit at least two housing packets before being housed because original applications expire. Because clients will usually wait through multiple housing package cycles, a client’s condition will sometimes change between evaluations.

Providers shared examples of clients receiving services to address mental health or substance abuse issues while waiting for permanent housing. When their package is renewed, the HRA determination may change to a lower level of care. From the Provider’s perspective, the client’s condition has improved because of those services, while the HRA determination assumes that the client no longer needs them.



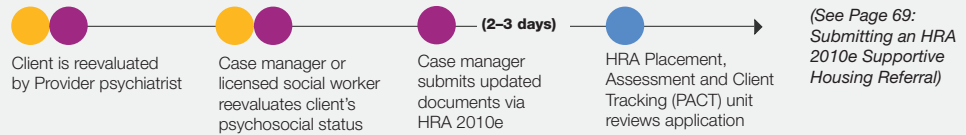
“You can’t be doing too well.”

—Provider

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step



Tools and Resources

- Updated psychosocial evaluation
- Updated psychiatric evaluation
- The status of housing placements is reported to DHS on a daily to weekly basis

Applying for General Population Housing

SIX MONTHS

For clients who are capable of living independently, general population housing may be the best option for permanent housing. Providers report encouraging some clients who have received determinations like Category E (ongoing substance abuse issues) from HRA, to apply for this type of housing. General population housing is housing without NY/NY categories and requirements. Some general population housing units provide social services, but not as extensive as NY/NY. Recommendations for general population housing are made by DHS and the Providers in collaboration with the client, based first on the absence of a medical or mental need, and second on whether the client meets the criteria for chronicity.

A complete DHS general population housing package includes:

- Cover letter
- Seven page application
- Psychosocial interview
- Proof of chronicity
- Birth certificate
- Social Security Card
- Proof of income, no more than 30 days old
- Photo ID

The application, to include all its contents, is valid for six months from the date the psychosocial assessment was completed. Psychiatric assessments are not required for general population housing applications.

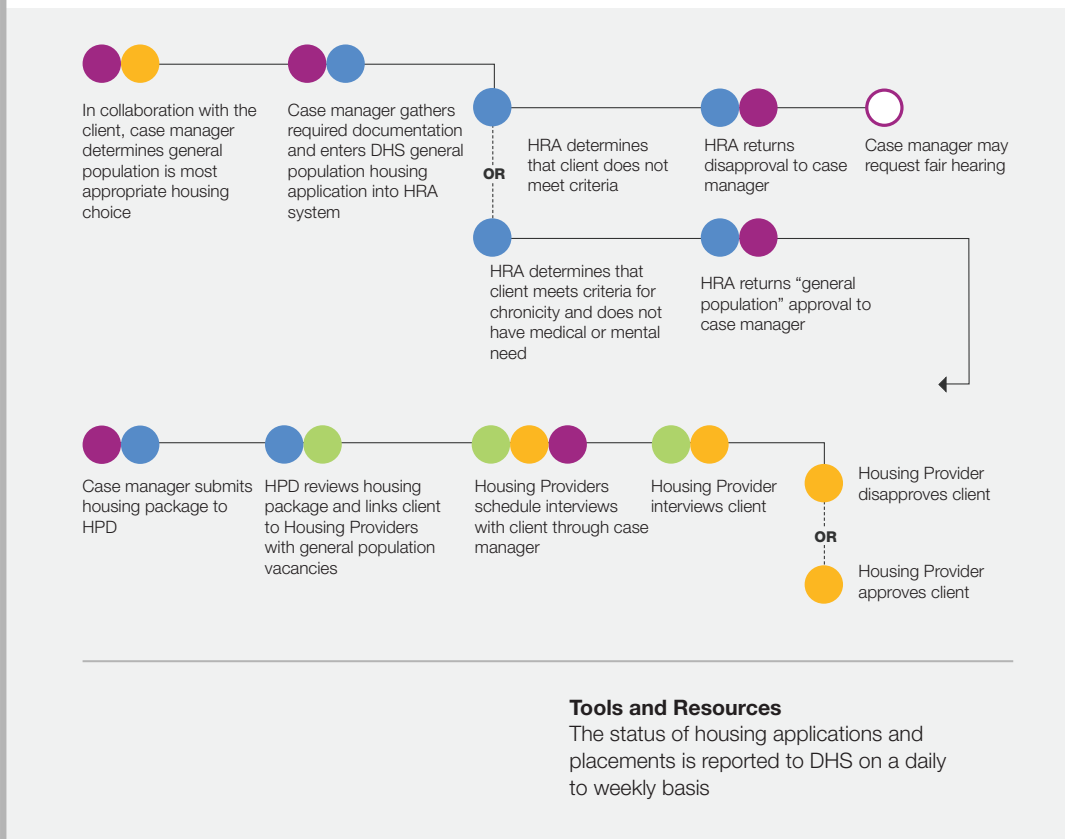
(see journey map on next page)

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Applying for General Population Housing (continued)

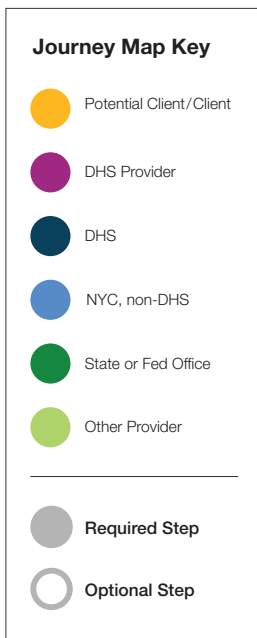


Obtaining an HPD Section 8 Voucher

SIX-NINE MONTHS ON AVERAGE

For eligible clients, the City may provide an HPD Section 8 rental subsidy for their permanent placement under the Housing Choice Voucher (HCV) program. The Section 8 program is the federal government’s major program for assisting very-low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market.

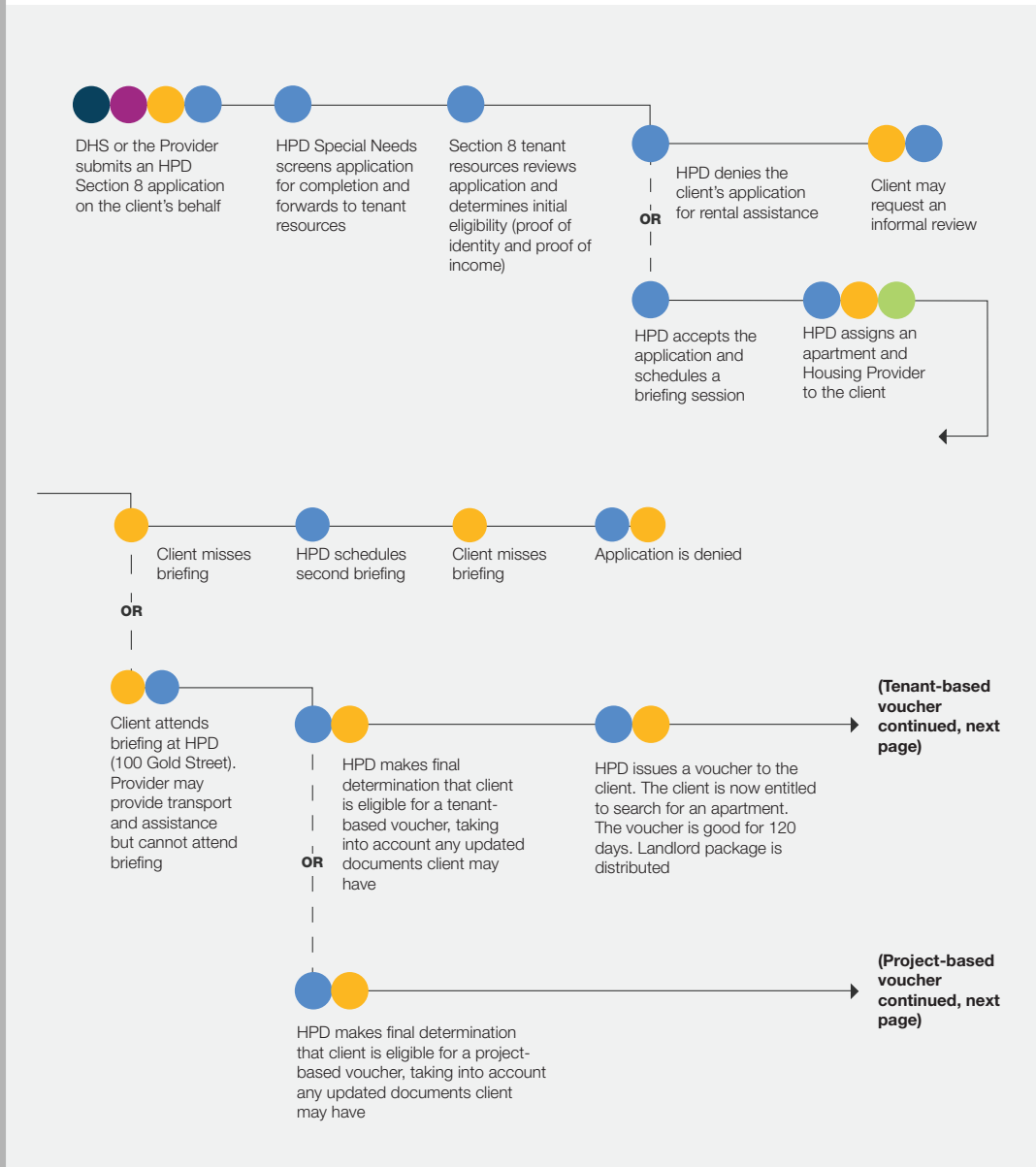
HPD’s Section 8 includes about 33,000 tenant-based vouchers that are available to households that meet HPD preference criteria, including HPD-programmed developments and DHS referrals. 99% of their clients are low-to-extremely-low income. Since 2014, HPD has allocated 500 tenant-based placement spots specifically to the shelter population. There are two primary types of Section 8 programs: project-based and tenant-based. HPD offers additional vouchers to DHS clients through the Supportive Housing program developments, which often use project-based vouchers. HPD tracks all Section 8 supportive housing client information, applications, vacancies, and placements in their system, called ELITE.



Obtaining an HPD Section 8 Voucher (continued)

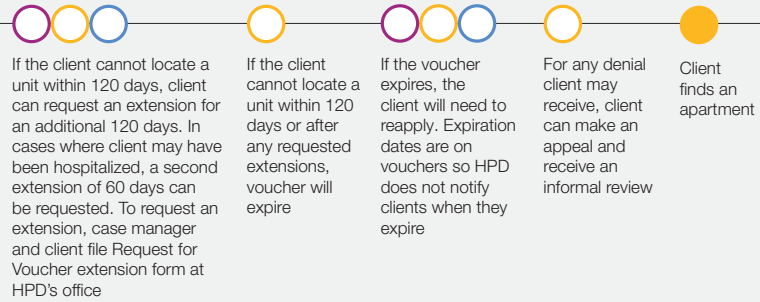
Project-based vouchers are a hybrid voucher, a voucher is tied directly to the unit, but after one year, the tenant may move with a tenant-based voucher to a market unit. The project-based unit also keeps a voucher, essentially resulting in a split of the voucher. When a client is approved for this type of rental subsidy, HPD works with the Provider and DHS to place the client. In these cases, the client is now “linked” to a placement.

Two additional non-Section 8 types of housing available through HPD to homeless clients are Shelter Plus Care and Moderate Rehabilitation Single Room Occupancy (SRO Mod) for Homeless households. Shelter Plus Care housing is



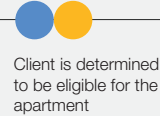
Obtaining an HPD Section 8 Voucher (continued)

Tenant-based voucher, continued

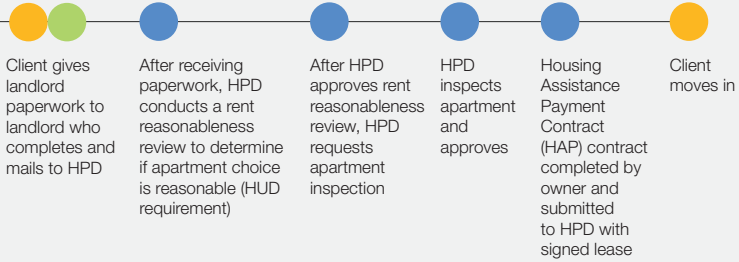


(HPD Section 8 voucher continued, below)

(Project-based voucher continued)



HPD Section 8 voucher, continued



Tools and Resources

The status of housing packets is reported to DHS on a daily to weekly basis.

intended for hard-to-serve homeless individuals with disabilities and includes supportive services at the placement. SRO Mod housing is designed to provide safe housing for homeless individuals in privately owned buildings and does not necessarily include supportive services as part of the placement.

Tenant-based vouchers are provided directly to the client and can be applied to any unit, as long as the unit meets the Department of Housing and Urban Development (HUD) Housing Quality Standards and the rent is determined reasonable by HPD. The Housing Choice Voucher is the largest and most



“Briefings are always held at HPD’s offices on 100 Gold Street, which is limited in parking and difficult to get into.”

—Provider

Obtaining an HPD Section 8 Voucher (continued)

commonly used tenant-based subsidy program, which assists very-low-income individuals and families in obtaining private, market-rate housing. If a client is found eligible for a tenant-based Section 8 voucher, they will be required to attend a briefing at the HPD office before they can receive the voucher.

In order to apply for Section 8 assistance, applicants must provide:

- Proof of citizenship or eligible immigration status
- Proof of Social Security Number

HPD serves approximately 5,400 clients per month at 100 Gold Street, where as they were previously only serving around 1,000. HPD conducted a recent survey in response to the perception of inconvenience and their overwhelming attendance at the service center (on the first floor of 100 Gold Street).

The survey included residents from Manhattan, the Bronx, and Brooklyn and most clients chose 100 Gold Street as their preferred location as opposed to being in the boroughs. HPD has asked the Department of Citywide Administrative Services (DCAS) to find them a new centralized space for their growing program. HPD cited the close location to the Fulton Transit Center as an amenity. Providers, however, reported 100 Gold Street as a challenging location to bring clients to due to limited parking, as they transport many clients in their vehicles.

If the client is still deemed eligible following the briefing, HPD will issue a voucher. The voucher will be active for 120 days. The voucher does not admit the client to the Section 8 program, but rather entitles the client to search for a placement using the voucher. The housing voucher details all of the program requirements that the apartment will need to meet in order to be approved for the rental subsidy.

Reasons for client missing a briefing:

- Client loses contact with case manager
- Hospitalization
- Jailed
- Entered in detox program
- Moving around or back on the street

After the briefing, the client receives:

- Section 8 voucher
- HPD Landlord Package

For clients who are applying for the Section 8 program, there are three main barriers that may keep them from receiving a rental subsidy.

Obtaining an HPD Section 8 Voucher (continued)

These include:

- Sex offender status
- Previous convictions for manufacturing methamphetamines in federally funded housing
- Owing money to HPD or any housing authority linked to the HCV program

Other barriers that may keep clients from gaining access to housing opportunities include:

- Bad credit
- Criminal justice system involvement
- Previous eviction from federally funded housing
- History of arson
- Previous termination for Section 8 assistance
- Drug use or related activity
- Reasonable cause to believe that substance use, including alcohol, may threaten the right to peaceful enjoyment of the premises by other residents
- Failing to provide information
- Failing to attend a briefing

Living in Communities (LINC) Rental Assistance Program

The Living in Communities (LINC) Rental Assistance program is another housing subsidy option for Providers and their clients to choose from. LINC was created jointly by HRA and DHS to target homeless individuals and families. To be eligible for LINC, clients must have an active case in CARES as of April 1, 2016, be employed for at least 30 days or receiving federal disability, and have an active or single-issue public assistance case. HRA runs a daily match with DHS to generate LINC certificates for clients who meet the eligibility requirements.

LINC is different from Section 8 and provides different incentives to landlords for participating in the program. With LINC, landlords are offered a signing bonus if they participate and can evict a tenant after five years if they cannot continue to afford the unit. LINC also has a less stringent building inspection process. HPD reports that based on these differences and tenant income, landlords have become particular about choosing tenants, which has created competition in an already saturated market. This extends the amount of time it takes to find housing for clients eligible for LINC.

HPD's Homeless Set Aside Units

HPD's Homeless Set Aside Units are normal affordable housing units with no additional social services. These units are set aside by regulatory agreement for housing projects and are restricted for individuals or families exiting shelter. It is highly unlikely that Providers would seek out this type of housing for their clients.



“You can complete this process and then not receive housing.”

—DHS

Waiting for Housing to Become Available

MONTHS–YEARS

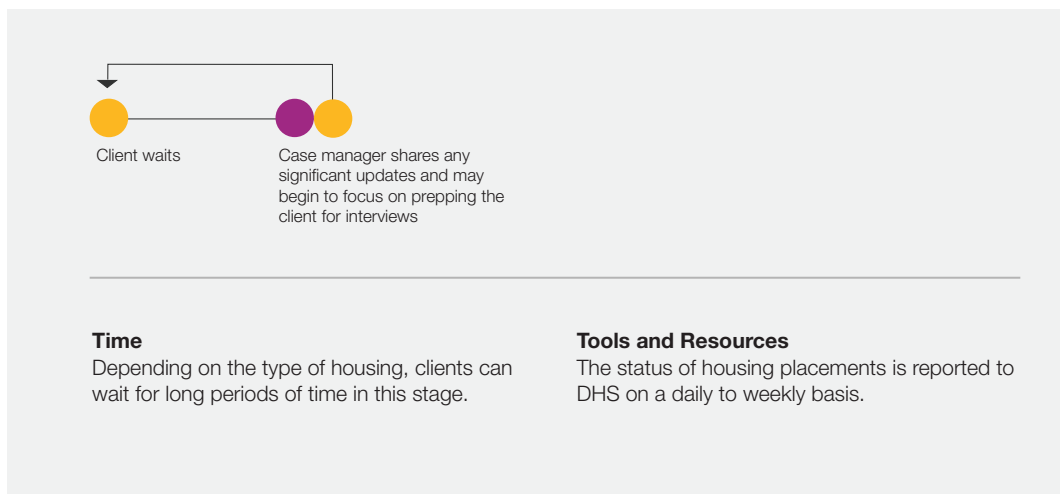
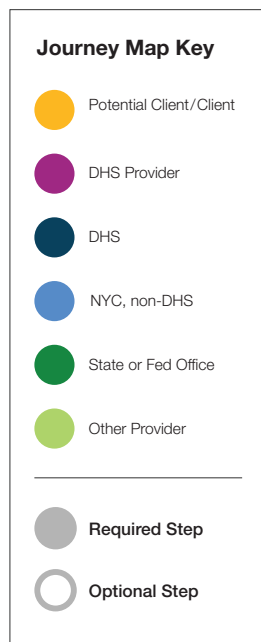
All Providers reported a critical shortfall of housing opportunities for their clients. Especially for certain types of housing, wait lists can be months to years long. For Example, NY/NY11 Category F Housing (for clients who have completed a substance abuse program) only has about 600 units citywide and turnovers and vacancies are rare.

During this time, clients may be moving between transitional settings, completing treatment or rehab programs, or living on the street. Providers reported that in this stage, clients are often not interested in day-to-day updates, but want to know bigger details like major changes in their case and when they might be permanently housed.

At this stage, clients will continue to face risks to their housing placement, including:

- Hospitalization
- Arrest and jail time
- Detox
- Benefits case sanctioned and closed
- Missed appointments
- Losing contact with case manager for unknown reasons

(see journey map on next page)



Section 9

Finding Housing Opportunities



Finding Supportive Housing Opportunities



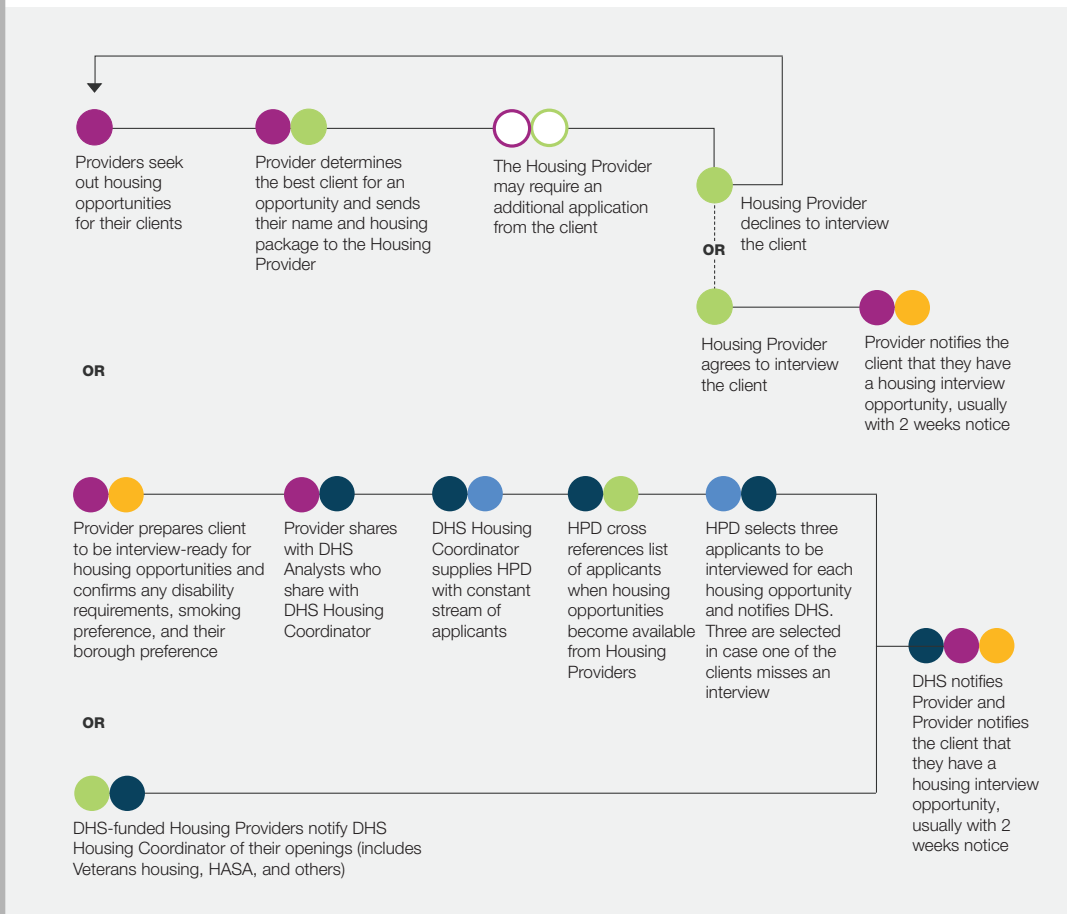
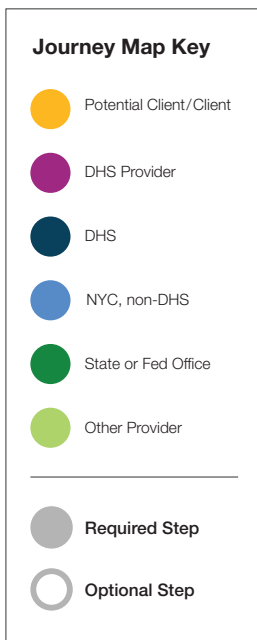
Accessing Mental Health Housing through SPOA

Once the HRA 2010e Supportive Housing Referral has been approved or Section 8 voucher obtained, Providers work to find housing opportunities for the client.

Finding Supportive Housing Opportunities

VARIES

DHS and Providers become aware of supportive housing opportunities through a number of channels. The paths diagrammed here are not all inclusive, but represent three of the most common ways that housing opportunities are identified for clients. Depending on the funding source of the housing opportunity, there may be more applications, interviews, or documentation steps required than are outlined here. This may in turn extend the housing application and placement process further.



Finding Supportive Housing Opportunities (continued)

Time

- Interview opportunity is noted in digital and physical case file
- Status of housing placements is reported to DHS on a daily to weekly basis

DHS manages a central waiting list of clients and uses a system based on program size to allocate housing units across the Providers

Supportive Housing Providers are always funded by a combination of HPD, DHS, and DOHMH. HPD pays capital while DHS and DOHMH cover social services. DHS reports that the different funding streams usually dictate how the City finds out about housing opportunities. One Provider reported that about 40–50% of interview opportunities per year come from DHS, while the Providers themselves seek out the remaining opportunities.

HPD reports the status of housing progress, availability, and placements to DHS on a daily to weekly basis, sometimes twice a day. This is a change HPD has made to help keep DHS more informed, but have found the increased reporting to be time consuming.

When Providers are notified about housing opportunities, they have to consider a number of factors when choosing which client to recommend for the placement, including:

- Type of opportunity
- Ability of the client to thrive in that particular opportunity
- How long the client has been waiting for placement

The Providers have a vulnerability index to prioritize clients for housing opportunities. Case managers can also advocate for particular clients to be placed early. Similarly, for specialized placements, analysts can negotiate for particular clients who would thrive in that placement. DHS reports that at times the allocation process is fluid and informal, based on the needs of a particular client or Provider.



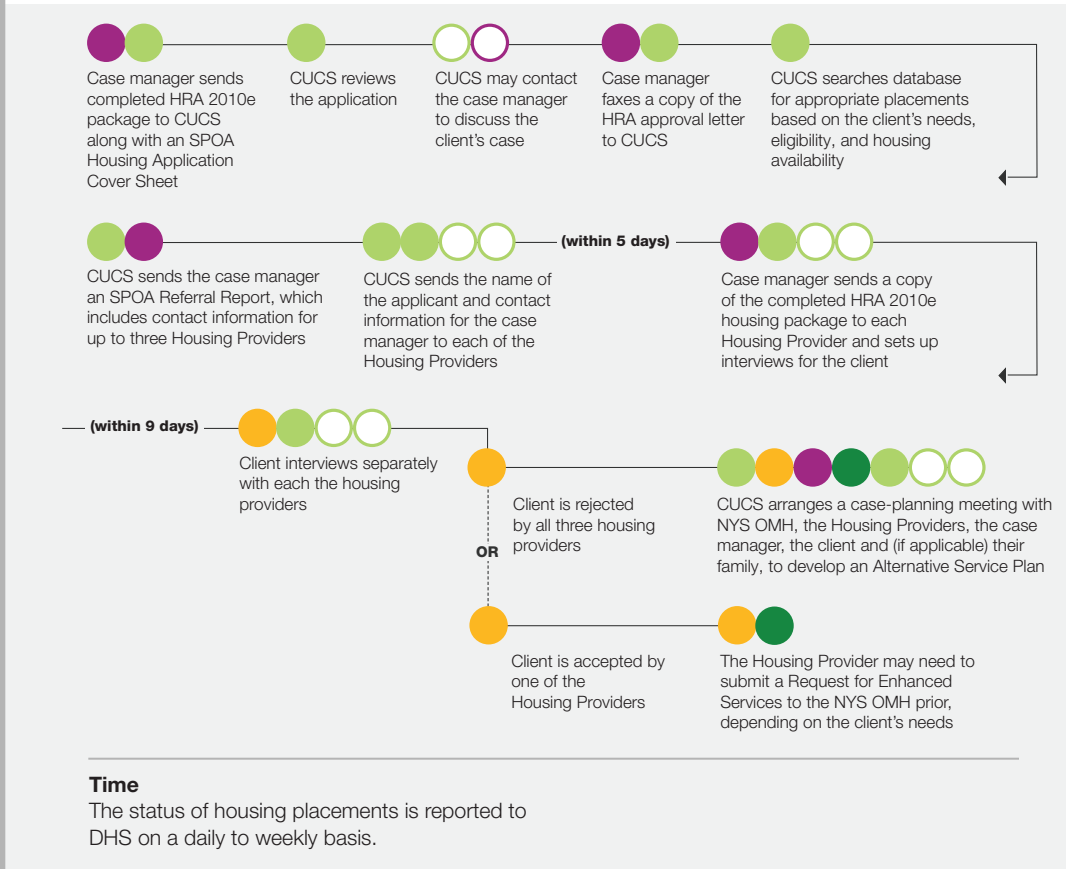
“There is too much reporting. We don’t have enough time to do the work.”

—HPD

Accessing Mental Health Housing through SPOA

TWO WEEKS FROM SUBMISSION

For clients with serious mental illness who are not NY/NYI or NY/NYII eligible, Single Point of Access (SPOA) housing, operated by the New York State Office of Mental Health (OMH) and Center for Community Urban Services (CUCS), may be an option. The SPOA program manages a database of vacancies in the mental health housing system in all five boroughs. To qualify, a client must have a serious mental illness; be discharged from a state-operated residence, center, or treatment facility; and be at risk of homelessness.



The following forms are required to access mental health housing through SPOA:

- Completed HRA 2010e housing packet
- SPOA Housing Application Cover Sheet
- HRA Approval Letter
- SPOA Referral Report
- Housing Provider Response Form

DHS reports that this type of housing may be underutilized due to its extensive application process, but is a good option for eligible clients requiring a higher level of care.

Section 10

Getting Linked with Housing

- 
- Getting Linked to Supportive Housing
 - Rejections by Housing Providers
 - Rejections by Clients
 - Housing Availability and Information
 - Securing a Tenant-based Section 8 Rental Subsidy

After clients submit their housing applications, it may take months to years before they are linked with a housing opportunity. There is no indication of when a housing unit may become available and once they are, many steps must be taken between various stakeholders for client selection and interviews. The long wait times between steps present challenges to keeping clients on track.

Getting Linked to Supportive Housing **MONTHS–YEARS**

In order to get linked to a supportive housing unit, clients must attend an interview with the Housing Provider. Interviews can be a difficult process for the client. Clients must also attend their interviews without their case managers and bring all of their documents with them. Case managers will provide support as needed to help clients prepare ahead of the interviews, including:

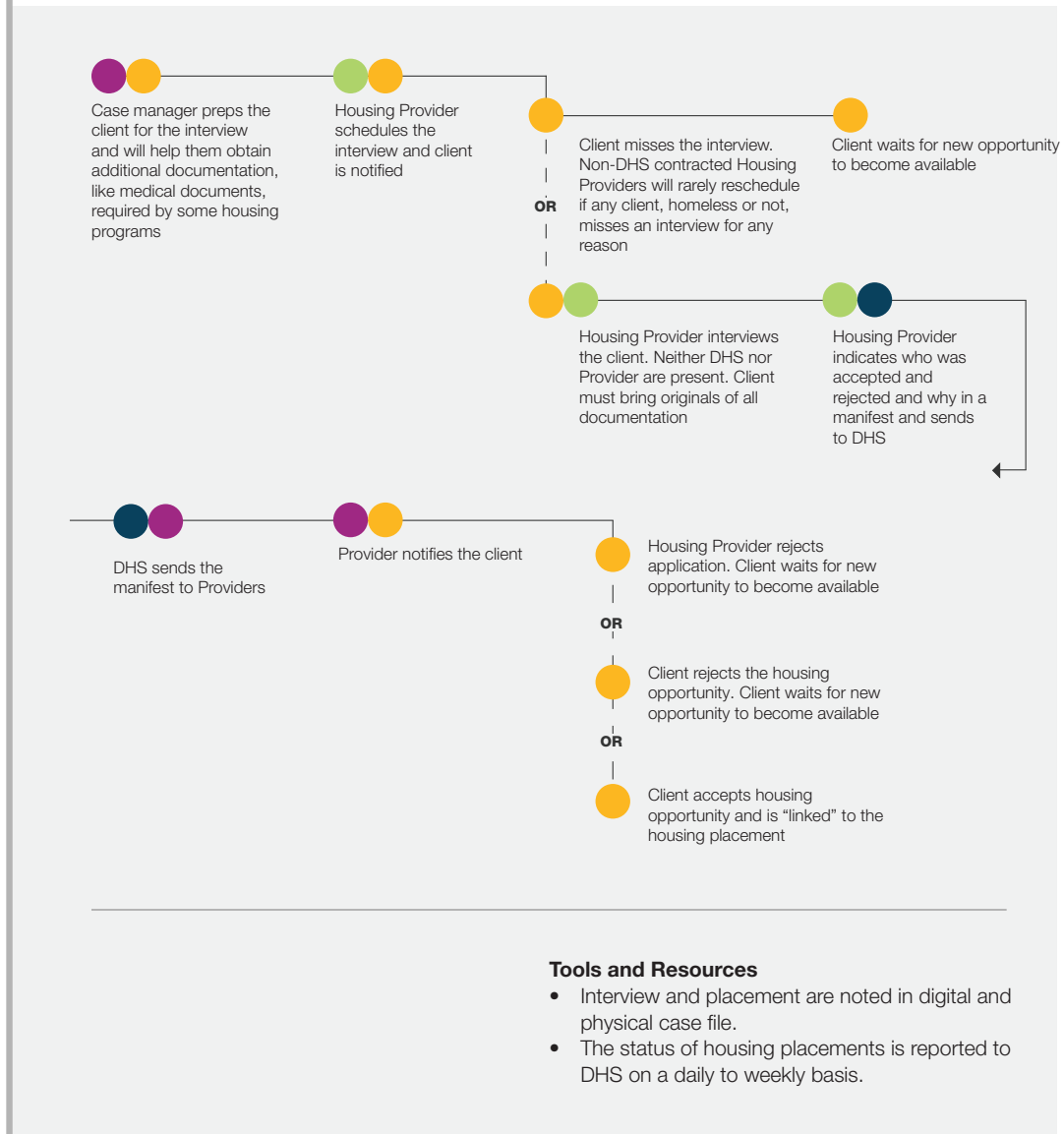
- Working through traumas
- Coaching them to be honest about their histories with foster care, jail, etc.
- Practice interviews
- Sending them on multiple interviews in a short period of time

A large percentage of clients have severe mental illness or heavy substance use issues. These conditions can make it difficult for clients to recognize how important the housing interview is to securing permanent housing. While clients are waiting, BRC (Bowery Residents' Committee) will coach them on self-sufficiency and how to live as independently as possible.

HPD requires three candidates for every housing opportunity, increasing the likelihood of a match, but also that two of the clients will not be accepted.

(see journey map on next page)

Getting Linked to Supportive Housing (continued)



Rejections by Housing Providers

HPD requires that DHS and Providers send three eligible clients to be interviewed for every vacant unit. This makes the interview process competitive and rejections common. HPD reports that it is typical for at least one client to miss an interview so having other candidates creates a better chance of filling an available unit. If a Housing Provider rejects all three, they must provide HPD with ample reason to receive a second round of candidates.

Rejections by Housing Providers (continued)

All Providers report that Housing Providers often reject clients for the same reasons that the client needs supportive housing. Common reasons for rejection include “does not have insight into their mental illness” or “needs higher level of care,” and often do not include further explanation. All Providers objected to these reasons, arguing that a key characteristic of mental illness is a lack of insight into the condition. Alternatively, some Providers like Breaking Ground and BRC are able to offer clients placement in facilities that they run.



“Certain Housing Providers want homeless people without homeless people problems.”

—Provider

Breaking Ground tracks acceptance and rejection metrics and reports that outside Housing Providers will accept clients about 25% of the time. They estimate that if they want to make 100 placements, they will need 400 interviews. Several Providers reported wanting to develop better relationships with Housing Providers, but have not had the resources to do so.

Rejections by Clients

Sometimes clients will reject housing opportunities based on location, size, shared arrangements, or proximity to certain institutions like hospitals. Especially for Staten Island or the Bronx, clients may be reluctant to leave or move to a particular borough. Many clients also reject congregate living situations.

Many times clients will attend interviews for housing units they know they will decline only to preserve their chances, for fear of losing their place in line. HPD has made efforts to avoid these situations by requesting that clients choose their preferences in the following categories for housing units:

- Borough location or exclusion
- Disability requirements
- Smoking or nonsmoking

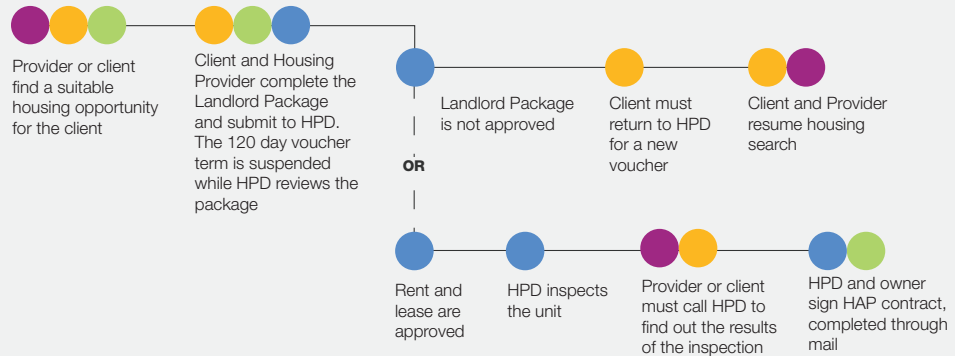
Housing Availability and Information

Providers report a lack of information about particular housing opportunities. For instance, when choosing a client to send, the Providers often do not have information about the full range of services at a location, the regulations in that particular building (e.g., curfews, metal detectors), or even the actual location of the building. A few Providers reported maintaining a catalog of units and buildings, but find the process difficult to maintain with limited resources.

Securing a Tenant-based Section 8 Rental Subsidy

WEEKS

For clients who have received a voucher for tenant-based Section 8 rental assistance, there are a number of steps that must be completed before signing a lease. Missing any of these steps can lead to a denial of assistance from HPD and losing the housing opportunity.



Tools and Resources

- Status of housing placements is reported to DHS on a daily to weekly basis

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

- Required Step
- Optional Step

Once the client has found an apartment, the client and landlord complete and submit an HPD Landlord Package, which includes basic information about the unit and lease as well as proof that the rent proposed for the unit is reasonable.

Providers mentioned that clients moving into new buildings face special challenges in this phase. An active Certificate of Occupancy is required for all buildings in the City, including Section 8 subsidy-approved units. HPD reports that the Certificate of Occupancy is almost always delayed, which further delays a client’s Section 8 voucher.

The final step in obtaining a Section 8 tenant-based subsidy is the execution of a Housing Assistance Payment (HAP) contract between the landlord and HPD. The contract describes the landlord’s responsibilities under the Housing Choice Voucher program and must be signed before HPD will provide rental assistance.

Securing a Tenant-based Section 8 Rental Subsidy (continued)

After the lease and HAP contract are signed, HPD will send the client a Rent Breakdown Letter, which specifies the dollar amount that the client will have to pay the landlord each month, after the subsidy has been applied.

The following documents are required to secure a tenant-based Section 8 rental subsidy:

- Section 8 voucher
- Housing Assistance Payment (HAP) contract
- HPD Section 8 Landlord Package

Section 11

Transitioning into Housing & Aftercare

- 
- Client Applies for One-Shot Deal
 - Client Signs Lease and Moves In
 - Case Manager Provides Aftercare

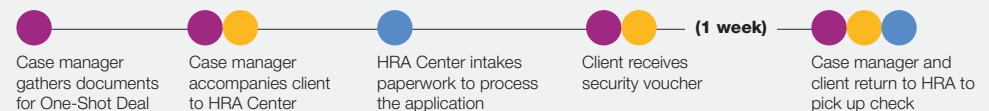
Once a client is placed into permanent housing, the case managers will continue to check in for 90 days to one year. Providers reported that many clients must relearn key skills and often require long-term care to live independently. Some people will fall out of their housing and need to restart the process again.

Providers report that this stage of the process varies widely for different clients. Providers and DHS report that the process is almost never straightforward and that what is represented here is an ideal procedure.

Client Applies for One-Shot Deal

DAYS–WEEKS

For many clients, the initial costs of moving into an apartment, like a security deposit, first and last month's rent or a furniture deposit, are too high to meet without further assistance. To secure those funds, many clients will apply at HRA for a One-Shot Deal, a one-time emergency payment by HRA meant to address these needs.



Tools and Resources

- Status of housing placements is reported to DHS on a daily to weekly basis.

Case managers accompany clients to an HRA Center for this application. Providers report that the experience at the HRA Centers can be stressful for clients. Wait times at the HRA Center are typically long, and sometimes, case managers and clients experience clerical errors that keep them from moving forward with the housing placement, therefore losing a housing opportunity. (See pages 62–63 for more on HRA centers.)

Stories from the Street

We made a stop at a small park that the Outreach Team frequents on their daily tours. Three of the people we saw are known to the team and they engage in friendly conversation. The outreach worker explains that all three have housing and return to the park every day because of familiarity and habit, sometimes for years. They emphasize how hard it is to “retrain” clients to live independently and take care of themselves.

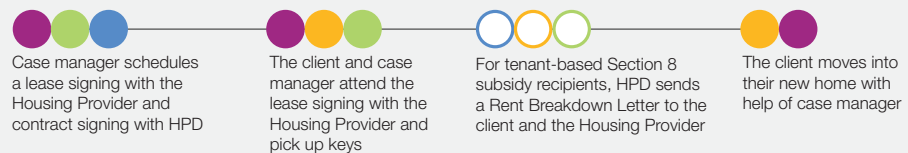
Client applies for One-Shot Deal (continued)

They may have to return multiple times. Providers generally accompany clients to the HRA Center to ensure they don’t give up during the long process and submit their application. Providers report that there had been no mechanism to escalate these issues and that there is an ongoing need to train HRA staff in how to appropriately serve this client population.

Client Signs Lease and Moves In

ONE-THREE WEEKS

Even at the lease-signing stage, Providers report that a housing opportunity may fall through or get delayed. For new buildings, getting Certificates of Occupancy and other documentation can delay move in by months. In other cases, Providers report that the team can’t always find the client to sign their lease.



Tools and Resources

- Lease agreement and Rent Breakdown Letter, if applicable, saved to digital and physical case file
- Status of housing placements is reported to DHS on a daily to weekly basis

Journey Map Key

- Potential Client/Client
- DHS Provider
- DHS
- NYC, non-DHS
- State or Fed Office
- Other Provider

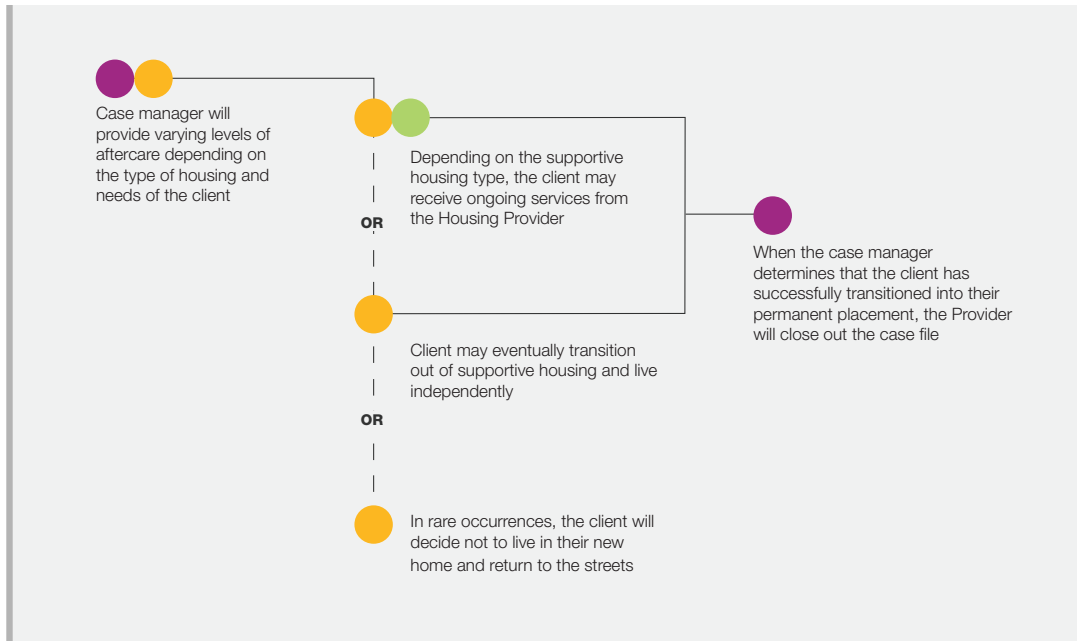
- Required Step
- Optional Step

Case Manager Provides Aftercare

THREE MONTHS–ONE YEAR

Most types of housing for the formerly chronically street homeless require some kind of aftercare. The length of aftercare varies by Provider and is often driven by grant reporting requirements rather than City requirements.

(See journey map on next page)

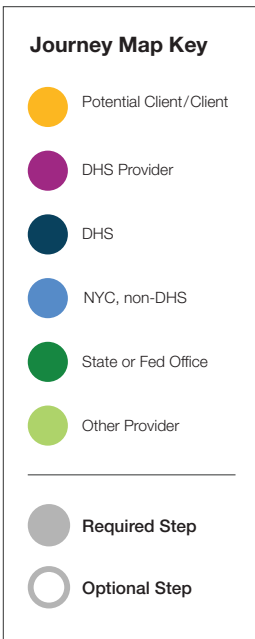


Once a client is determined to have successfully transitioned into their placement, the Provider will close their case file. Criteria for closing a case file may include up-to-date rent payments, compliance with medication, and a strong relationship with their new case manager or Housing Provider. This criteria is usually based on the Provider and the case manager’s assessment of the client’s progress.

Providers report even when permanently housed, some clients may continue to return to the locations they frequented while homeless. Both DHS and Providers shared that it is not uncommon to receive a 311 call about or encounter a former client who is now permanently housed but is perceived to be homeless because they are panhandling or appear to be unoccupied.

For programs like LINC, which has no aftercare, clients will sometimes struggle to live independently and are at risk of falling out of housing and starting the process over again. In these cases, some Providers give extensive aftercare to keep clients permanently housed. For all permanent housing placements, clients will pay their own rent either with personal income and or government assistance.

Supportive housing is designed to help clients live independently. In some cases, these clients will graduate out of the supportive setting and live on their own. For other clients, they will continue to live in a supportive setting where they can receive ongoing care.





Mayor's Office of Operations
November 2017

