Minnesota Ryan White HIV/AIDS Program
Service Area Standards: Housing Rental Assistance

HRSA Definition: Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services). Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance: HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Universal Standards: All subrecipients must meet universal standards requirements in addition to service area standards for which they are funded.

Definitions:
Assessment: Individual evaluation of an HIV positive individual's medical care and risk status, knowledge of disease, barriers to accessing medical care and awareness of resources.

Coordination: Working with other service providers to ensure efficiency and eliminate duplication of efforts.

Core medical services: HIV primary medical care--including ambulatory outpatient HIV clinic services, AIDS Drug Assistance Program, oral health care, outpatient mental health care, outpatient substance abuse treatment, medical nutritional therapy, medical case management including treatment adherence, early intervention services, home health care services and specialty medical care referrals.

In care: A person is considered to be in care when he or she is receiving primary HIV medical care (clinical evaluation and clinical care) at a minimum of every six months. This medical care should meet U.S. Public Health Service guidelines for the treatment of HIV/AIDS.

Linkage: Successful engagement of a client into primary HIV medical care, with the understanding that current barriers to returning to care at recommended intervals are addressed; client is assessed as being likely to keep HIV medical appointments in the near future.
Non-medical support services: Services that address barriers to people living with HIV/AIDS accessing and remaining in primary medical care.

Non-permanently Housed: Includes transitional housing for homeless people, temporary arrangement to stay with family or friends, other temporary arrangements such as a short-term housing subsidy, and temporary placement in an institution (e.g., hospital, psychiatric hospital, substance abuse treatment facility, or detox center).

Out of care: An individual that has not accessed primary HIV medical care within the last six months.

Points of entry: Health care and human services access points used frequently by traditionally underserved HIV-positive individuals to help meet their medical and social service needs. They are therefore key access points for referring such individuals into the HIV care system. Examples are health departments, emergency rooms, substance abuse programs, mental health programs, detention facilities, STD clinics, homeless shelters, counseling and testing sites, federally qualified health centers, and other healthcare points of entry that have established referral relationships/agreements with Part A funded Early Intervention Services providers.

Unstable Housing: Includes emergency shelter; any location not designed for use as sleeping accommodation (e.g., vehicle, abandoned building, bus/train/subway station, airport, outside); jail, prison, or juvenile detention facility; and hotel/motel paid for with emergency shelter voucher.

Payment Standards: Calculations used to determine client's portion of the rent. The calculation is based on income and family size. Provider will use HUD payment standards calculator to determine client contribution.

Short Term: Limited to a cumulative period of 24 months per household. (See notation from page 1.)

Standard	Measure	Data Source
Individual Client Focused Standards		
1. Housing Services- Rental Assistance: Government Regulations – Safety & Livability 1.1 Agency complies with HRSA/HUD requirements for approved housing. 1.2 Agency shall ensure housing unitsmeet HUD housing standards. 1.2 an Agency shall have system in place toensure that housing units were inspectedand passed HRSA/HUD requirements. 1.3 Households with one or more children under the age of six and/or pregnant women that occupy housing built before 1978 must have a visual leadbase inspection for deteriorated paint – initially and annually.	1.1 Compliance with all appropriate regulatory agencies for safety and livability. 1.2-1.3 Agency has documentation of HUD housing standards and lead based paint inspection requirements. Every housing unit passesinspection.	1.1 Documentation of updated HRSA/HUD requirements on file. 1.2 – 1.3 Documentation of facilities reviews on file.
2. Distribution of Housing Services- Rental Assistance: 2.1 Agency has recipient-approved policy in place to address waiting lists in conjunction with coordinated assessmentif applicable 2.2 Housing services clients complete a brief assessment of their housing history, current housing needs and barriers to securing and maintaining affordable housing 2.3 Comply with local jurisdiction's Housing and Redevelopment Authority Payment Standards. • A "payment standard" is the term used to state the *maximum amount* thatmay be utilized for a rental unit. • Utility Allowance: A "utility allowance" is a published amount that can be utilized into a housing payment formula to give some relief	2.1 Policies and procedures in place. 2.2 Assessment in place. 2.3 Policies and procedures inplace and practiced.	2.1 File Review/SiteVisits 2.2 File Review/SiteVisits 2.3 File Review/SiteVisits

Standard	Measure	Data Source
to the low-income resident who is in the program. A formula is used to calculate the housing payment, and the provider can either pay the utility company or have the resident pay the utility directly. • Client Contribution: Must utilize HUD income calculator to determine clients' contribution to their housing cost.		
3. Client Records 3.1 Documentation of intake, brief assessments, and client eligibility (Clientmeets Ryan White eligibility requirements and is homeless, unstable, or non-permanently housed). 3.2 Document collaborative contacts onbehalf of the client in an effort to get them stably housed. 3.3 Documentation demonstratesadherence to case closure policy.	3.1. Client files contains intake, assessments, client eligibility, and case notes onmonthly contacts. 3.2. Documentation inprogram records. 3.3 Program policy and procedure in place to meet guidelines.	3.1. File review/SiteVisits 3.2 File review/SiteVisits 3.3 File review/SiteVisits
4. Client Intake 4.1 Clients meet Ryan White eligibilityrequirements. 4.2 Agency shall provide intake and briefassessment of rental assistance needs **and medical care status.** 4.3 Clients are informed of services available and what client can expect ifs/he enrolls in services. 4.4 Client information is collected tofacilitate referrals and follow-up as necessary.	4.1 Documentation in program and client files. 4.2 Documentation in clientfiles and program file. 4.3 Description of services and client responsibilities areincluded in client's signed consent form. 4.4 Documentation in client file.	4.1 File Review/SiteVisits 4.2 File Review/SiteVisits 4.3 File Review/SiteVisits 4.4 File Review/SiteVisits

Standard	Measure	Data Source
Program Focused Standards		
5. Referral and Coordination 5.1 Referral, coordination, and confirmed linkage with medical case management will occur for clients experiencing multiple barriers to care as indicated by the brief assessment. 5.2 Program staff shall assist clients with obtaining housing, facilitating housing searches and Landlord negotiations, completing initial and yearly inspections, and lease signings. 5.3 Program staff shall educate clients on how to access services, including medical case management for clients experiencing multiple barriers to care. 5.4 Program staff shall make available ahousing directory. 5.5 Program staff shall document allservices performed including the time spent andcommunications with client or services provided on behalf of a client. 5.6 Program Staff help clients develop a transition plan to access long-term housing.	5.1. Formal and informal memorandum of agreement on file for referral and coordination with medical case management providers. 5.2 Documentation in program file. 5.3 Coordination and confirm linkage to MCM documented in client fil. 5.4 Documentation in client file. 5.5 Documentation in client file and CDL reporting as defined in contract. 5.6 Documentation in client file.	5.1- 5.6 File Review/Site Visits
6. Staff Qualifications andTraining 6.1 Housing Specialist • Bachelor's Degree in Health or Human Services or related field. • Minimum one-year experience in housing or social services related work or a combination of education and experience providing equivalent knowledge. • Staff is knowledgeable about available resources to avoid duplication of services.	6.1 Programs are staffed with personnel with knowledge of housing services, HIV, and have the skills and experience to work with populations most impacted by HIV.	6.1-6.3 File Review/Site Visits Program file contains documentation of all current direct service staff including resume, education, work experience, skills, and training needs/plans

6.2 Housing Specialist Training Requirement: Attend a minimum of two professional trainings annually. Topics for trainings may include Housing, Chemical Health, and Mental Health. 6.3 Lead-based paint: Specific staff conducting lead-based paint inspection will have an annual training on lead-based paint.	6.2-6.3 Dates and topics of training will be documented	