MISSOURI OUTSTATE SERVICES MANUAL

Missouri Department of Health and Senior Services

Bureau of HIV, STD, and Hepatitis

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PURPOSE:

The Missouri (MO) Ryan White (RW) Part B Outstate Services Manual is intended to be used by MO Human Immunodeficiency Virus (HIV) Case Managers as a reference for the various policies and procedures related to RW Part B Outstate Services.

GOAL:

The goal of the RW Part B Outstate Service Manual is to assist MO HIV Case Managers in the Outstate area of MO with identifying the various policies and procedures related to RW Part B Programs and ensure compliance with Federal mandates.

SUMMARY:

RW Part B Program Outstate Services has established the following policies and procedures to ensure consistent criteria are used for eligibility and enrollment, client access to core HIV-related medical services, and compliance with Federal mandates.

POLICY:

1. Outstate Services are available to eligible clients at the discretion of the Department of Health and Senior Services (DHSS), as funding permits.
2. Clients who request access to Outstate Services must be engaged in the MO HIV Medical Case Management system or the Direct Enrollment Services (DES) Program. (HIV Case Management Manual Section 3.0 and Statewide Services Manual (SWS) Manual Section 8.1)
3. Outstate Services policies and procedures vary depending on the individual program or ~~s~~service category. (See individual Outstate Services descriptions and policies for details.)
4. RW Part B Program service referrals must be in "8ENR" status when services are rendered, if requesting assistance.
5. An exception request may be submitted to the DHSS HIV Support Services Coordinator for emergency situations where a delay in RW Part B service enrollment could result in a barrier to care. (Examples of delays may include a client's ability to obtain and submit required eligibility documentation, delays in processing RW Part B referrals, etc.)
6. The documentation provided as part of the initial enrollment process into the MO HIV Medical Case Management system may be used for Outstate Services eligibility documentation. Documentation includes: (HIV Case Management Manual Section 3.0)
    a. Proof of HIV+ status
    b. Proof of residency
    c. Proof of income, which meets the current 0-300% Federal Poverty Level (FPL) income requirements
7. Clients who do not submit all required or requested documentation will not be eligible for Outstate Services.

8. DHSS or the DHSS Benefits Administrator may request additional information at any time before or after a client's enrollment in any Outstate Service.

PROCEDURE:

1. Case Managers must upload all required HIV Case Management system eligibility documentation into the electronic client database before clients can become enrolled in the requested Outstate Services. (HIV Case Management Data Rules)
2. Case Managers must enter all Outstate Services referrals into the "Service Referral" module in the electronic client database.
3. Case Managers must use the most current forms located in the electronic client database.
4. The DHSS HIV Support Services Coordinator or the DHSS Benefits Administrator will review all required or requested documentation before Outstate Services enrollment.
5. The DHSS Benefits Administrator will activate requested Outstate Services referrals if approved.

DOCUMENTATION:

1. Proof of HIV Case Management eligibility (HIV Case Management Manual Section 3.0)
2. Outstate Services documentation, per individual policy
3. Other documentation, as requested

SUMMARY:

Removal and Closure policies and procedures have been established to ensure consistent criteria are used when necessary to address issues that could result in a client's suspension or removal from Outstate Services.

POLICY:

The following conditions may result in permanent removal or time-limited closure of Outstate Services:

1. Endangering the life of a case manager(s), agency staff, public health official, etc.
2. Threatening and/or abusive behavior
3. Fraud
4. Criminal activity on agency property
5. Disrespectful or discourteous behavior
6. Failure to meet eligibility requirements
7. Failure to respond to requests for updated information
8. Client has moved out of the state

PROCEDURE:

1. Case Managers must consult with their agency supervisor regarding circumstances leading to closure, per their agency's protocol. Situations involving items 1 – 5, discussions must also include other parties, including the DHSS HIV Support Services Coordinator, AIDS Drug Assistance Program (ADAP) and Core Services Director, regional Quality Services Manager (QSM), regional supervisor, client, etc., as appropriate. A closure determination will include the time frame for closure and any stipulated requirements that must be met prior to readmission, if eligible. (SWS Manual Section 3.0).
2. Case Managers must document all activities leading to the decision for removal or closure in a "Progress Note" in the electronic client database.

3. Case Managers must notify the client in writing that they have been closed to Outstate Services. The letter must include the reason for closure, the beginning and end date, or the timeframe for closure (e.g., one month, one year, permanently, etc.), and any stipulated requirements that must be met prior to readmission. (Written notification of the closure may also come from DHSS, the agency supervisor, regional supervisor, QSM, etc., as appropriate.)
4. Case Managers must coordinate the notification of the closure letter for clients who are unable to receive mail.
5. Case Managers must document conversations with the client about the closure in the "Progress Note" section of the closure encounter in the electronic client database. (HIV Case Management Manual Section 2.0)
6. The Case Manager, DHSS, agency supervisor, regional supervisor, or QSM must upload a copy of the closure letter into the "Documents" module of the electronic client database and notify the DHSS Benefits Administrator via communicate that the client has been closed or removed from services.
7. The DHSS Benefits Administrator must change the status of the client's referrals from an "8ENR" to "7CLS" upon removal or closure from Outstate Services. Case Managers will be responsible for closing the HIV Case Management referral, as needed. (HIV Case Management Manual Section 7.0)
8. The DHSS Benefits Administrator will ensure that all relevant service providers are notified that the client has been removed or closed out of Outstate Services.

DOCUMENTATION:

1. Client removal letter
2. Documentation to support removal or closure, if applicable
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The following policies and procedures have been established to provide a consistent mechanism for clients to object or appeal decisions regarding Outstate Services eligibility.

POLICY:

1. Clients have a right to participate in grievance procedures when they believe their rights have been violated.
2. Outstate Services follows the MO HIV Medical Case Management system's policies and procedures when a client has a complaint, grievance, or wishes to appeal a decision. (HIV Case Management Manual Section 2.0)

PROCEDURE:

1. Case Managers must refer to the current Complaint, Grievance, and Appeal Policy and Procedure of the HIV Case Management Manual (HIV Case Management Manual, Section 2.0)
2. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. HIV Case Management Manual Complaint, Grievance, and Appeal Policy and Procedures (HIV Case Management Manual Section 2.0)
2. Documentation to support complaint, grievance, or appeal
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

MO RW Part B Program outstate core services are reserved for eligible clients in the Outstate (Central, Northwest, Southeast, and Southwest) regions of MO. Core services include Outpatient Ambulatory Medical Care, Vision, Oral Health Care, Mental Health, and Outpatient Substance Abuse assistance.

POLICY:

See individual subsections for applicable policies.

PROCEDURE:

See individual subsections for applicable procedures.

DOCUMENTATION:

See individual subsections for applicable documentation.

SUMMARY:

RW Part B Program outpatient ambulatory medical care assistance helps provide access to healthcare-related services for eligible clients who lack adequate financial resources, public or private health insurance, etc.

POLICY:

1. RW Part B Program services are available based on current funding.
2. Clients must meet the minimum MO HIV Case Management eligibility criteria to qualify for Outstate Services. (HIV Case Management Manual, Section 3.0)
3. The RW Part B Program cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
4. Some health-related services may not be covered by the RW Part B Program. Please refer to the most current version of the ADAP and Health Insurance Continuation Program (HICP) Statewide Service Limitations and Exclusion list located in the electronic client database. (MO Support Files/ADAP.)
5. RW Part B Program services can generally only provide payment for outpatient services.
6. Clients must utilize all other available sources of outpatient ambulatory care if eligible to ensure RW remains the payer of last resort. Including accessing public health coverage such as MO HealthNet (MHN), People with Disabilities (PWD) Program, Medicare, employer-sponsored plans, private health insurance, and Affordable Care Act (ACA)/ Marketplace health insurance plans, etc., if applicable.
7. Clients who have served in the United States military may be eligible for health care services through the Veteran Administration (VA). (SWS Manual Subsection 5.1.)
8. Case Managers must enter an Individual Service Plan (ISP) for uninsured clients (HIV Case Management Data Rules) to document the reason for requesting Outpatient Ambulatory Medical Care Assistance prior to RW Outstate Services approval. An ISP is only needed for individuals who do not have health insurance.
9. Clients who have chosen to miss or decline opportunities to access other available payer sources for health insurance costs must complete and sign an ADAP and HICP Affidavit of

Missed or Declined Health Insurance Form before becoming enrolled in ADAP or HICP, and during each annual update regardless of the reason. (SWS Manual Appendix A2)

PROCEDURE:

1. Case Managers must make an "HSI - Ambulatory/Outpatient Medical Care" service referral for uninsured clients or "HSI – Ambulatory/Outpatient Medical Care Co-pays" for insured clients.
2. The new service referral should be submitted in "1RFR" status. If the client already has an active service referral for any service adding a new referral at "1RFR" status is unnecessary. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
4. The DHSS Benefits Administrator will review the service referral to ensure all documentation has been added. If approved, the service referral status will be changed to "8ENR" to enroll the client in RW Part B Outstate services.
5. Case Managers must enter all health insurance coverage information, if applicable. (HIV Case Management Data Rules)
6. Case Managers must ensure that all clients who would likely qualify apply for all other payer sources, which have minimum essential coverage, within 30-days of initial enrollment into the RW Part B Program. (SWS Manual Section 5.2)
7. Providers, Case Managers, or clients must submit a copy of the provider claim form and Explanation of Benefits (EOB) to the DHSS Benefits Administrator to be paid for allowable outpatient ambulatory medical care.
8. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Optional MHN Pre-Eligibility Screening and Application Tool results, if applicable (SWS Manual Appendix A1)
2. Completed MHN application, if applicable
3. MHN Program(s) eligibility determination
4. Private insurance member card, if applicable
5. ADAP and HICP Affidavit of Missed or Declined Health Insurance form, if applicable (SWS Manual Appendix A2)
6. Provider claim form
7. EOB
8. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

RW Part B Program vision assistance helps provide essential vision-related services for eligible RW Part B clients when no other payer source exists.

POLICY:

1. RW Part B Program services are based on the availability of current funding.
2. Clients must meet the minimum MO HIV Case Management eligibility criteria to qualify for RW Part B Program services. (HIV Case Management Manual Section 3.0)
3. RW Part B Program vision assistance is limited to **one** each of the following per grant year:
    a. comprehensive exam (with rates up to $115),
    b. one set of frames (up to $100), and
    c. one set of lenses:
        - Single Vision (Up to $40 per lens)
        - Bi-Focal (Up to $55 per lens)
        - Tri Focal (Up to $75 per lens)
4. RW Part B Program services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
5. Clients must utilize all other available sources of vision assistance programs if eligible to ensure RW remains the payer of last resort. Including accessing public health coverage such as MHN, Medicare, employer-sponsored plans, private health insurance, and ACA Marketplace health insurance plans, etc., if applicable.
6. Clients who have served in the United States military may be eligible for health care services through the VA. (For more details regarding VA services, please refer to the SWS Manual Section 5.1)
7. Uninsured clients who wish to access RW Part B Program vision assistance must see a contracted provider.
8. Privately insured clients may receive assistance with co-pays for eligible RW Part B Program vision services.

PROCEDURE:

1. Case Managers must enter an "HSI – Vision" service referral into the electronic client database.
2. The new service referral should be submitted in "1RFR" status. If the client already has an active service referral for any service, adding a new referral at "1RFR" status is not necessary. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
4. The DHSS Benefits Administrator will review the service referral to ensure all documentation has been added. If approved, the service referral status will be changed to "8ENR" to enroll the client in RW Part B Program vision services.
5. Case Managers must enter all vision insurance coverage information, if applicable. (Statewide Data Rules)
6. Providers, Case Managers, or clients must submit a copy of the provider claim form and EOB to the DHSS Benefits Administrator to be paid for allowable vision services

DOCUMENTATION:

1. Provider claim form
2. EOB
3. Private insurance member card, if applicable
4. Other documentation, as requested by DHSS or DHSS Benefits Administrator

SUMMARY:

RW Part B Program oral health care assistance helps provide essential oral healthcare-related services for eligible RW Part B clients when no other payer source exists.

POLICY:

1. RW Part B Program services are based on the availability of current funding.
2. Clients must meet the minimum MO HIV Case Management eligibility criteria to qualify for RW Part B Program services. (HIV Case Management Manual Section 3.0)
3. RW Part B Program oral health care assistance covered services for uninsured clients include:
    a. emergency care/pain alleviation
    b. endodontic (root canal)
    c. periodontal (gum disease)
    d. preventative procedures such as examinations
    e. x-rays
    f. cleanings
    g. composite fillings and extractions
    h. prosthetic (dentures)
    i. restorative care and oral surgery (limited)
4. RW Part B Program oral health care assistance services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
5. Clients must utilize all other available sources of oral health care assistance programs if eligible to ensure RW remains the payer of last resort. Including accessing public health coverage such as MHN, Medicare, employer-sponsored plans, private health insurance, and ACA Marketplace health insurance plans, etc., if applicable.
6. Clients who have served in the United States military may be eligible for health care services through the VA. (For more details regarding VA services, please refer to the SWS Manual Section 5.1)

7. Uninsured clients who need to access RW Part B Program oral health care assistance must see a contracted provider.
8. Privately insured clients may receive assistance for co-pays for eligible RW Part B Program services.
9. Clients will not be eligible for assistance once they reach their oral health insurance plan coverage caps or limitations (i.e., additional co-payments or other services).

PROCEDURE:

1. Case Managers must enter an "HSI - Dental" service referral for uninsured clients or "HSI – Dental Co-Pays" service referral for insured clients into the electronic client database.
2. The new service referral should be submitted in "1RFR" status. If the client already has an active service referral for any service, adding a new referral at "1RFR" status is unnecessary. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
4. The DHSS Benefits Administrator will review the service referral to ensure all documentation has been added. If approved, the service referral status will be changed to "8ENR" to enroll the client in RW Part B Outstate services.
5. Case Managers must enter all oral health insurance coverage information, if applicable. (HIV Case Management Data Rules)
6. Providers, Case Managers, or clients must submit a copy of the provider claim form and EOB to the DHSS Benefits Administrator to be paid for allowable oral health services.

DOCUMENTATION:

1. Provider claim
2. EOB
3. Private oral health insurance member card, if applicable
4. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

RW Part B mental health assistance helps provide essential mental health-related services for eligible RW Part B clients when no other payer source exists. Services may include mental health professional office visits, evaluations, and payment for medications if included on the current ADAP Formulary.

POLICY:

1. RW Part B Program services are available based on current funding.
2. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for RW Part B Program services. (HIV Case Management Manual Section 3.0)
3. RW Part B Program mental health assistance is limited to:
    a. outpatient services only,
    b. one annual psychiatric evaluation per year,
    c. twelve additional psychiatric service visits or medication checks may be authorized per program year,
    d. twenty-five therapy visits may be authorized per program year. Individual and family therapy, including the client, is permitted.
4. RW Part B Program services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
5. Clients must utilize all other available sources of mental health assistance programs, if eligible, to ensure RW remains the payer of last resort. Including accessing public health coverage such as MHN, Medicare, employer-sponsored plans, private health insurance, including ACA Marketplace health insurance plans, etc., if applicable.
6. Clients who have served in the United States military may be eligible for health care services through the VA.
7. Uninsured clients who wish to access RW Part B Program mental health assistance must see a contracted provider and have a prior authorization approved prior to services being rendered.
8. Insured RW Part B clients may receive services without a prior authorization for allowable mental health services if their primary insurance covers the service.

9. Clients will not be eligible for assistance once they reach their health insurance plan coverage caps or limitations (i.e., additional co-payments or other services).

PROCEDURE:

1. Case Managers must enter an "HSI - Mental Health Counseling" service referral for uninsured clients or "HSI – Mental Health Counseling Co-Pays" for insured clients into the electronic client database.
2. The new service referral should be submitted in "1RFR" status. If the client already has an active service referral for any service, adding a new referral at "1RFR" status is unnecessary. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
4. The DHSS Benefits Administrator will review the service referral to ensure all documentation has been added. If approved, the service referral status will be changed to "8ENR" to enroll the client in RW Part B Outstate Mental Health Assistance services.
5. Case Managers must enter all health insurance coverage information, if applicable. (HIV Case Management Data Rules)
6. Providers, Case Managers, or clients must submit a copy of the provider claim form and EOB to the DHSS Benefits Administrator to be paid for allowable mental health services.

DOCUMENTATION:

1. Provider claim form
2. EOB
3. Private insurance member card, if applicable
4. Other documentation, as requested by DHSS or DHSS Benefits Administrator

SUMMARY:

RW Part B Program substance abuse assistance helps provide essential substance abuse-related services for eligible RW Part B clients when no other payer source exists. Services may include mental health professional office visits, evaluations, and payment for medications if it is included on the current ADAP Program Formulary.

POLICY:

1. RW Part B Program services are available based on current funding.
2. Clients must meet the minimum MO HIV Case Management eligibility criteria to qualify for RW Part B Program services. (HIV Case Management Manual Section 3.0)
3. RW Part B Program substance abuse assistance is limited to:
    a. office visit for a new patient,
    b. office visit for an established patient,
    c. detox or detoxification,
    d. residential treatment services,
    e. individual counseling, and
    f. drug assessment/screenings.
4. RW Part B Program services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
5. Clients must utilize all other available sources of substance abuse assistance programs if eligible to ensure RW remains the payer of last resort. Including accessing public health coverage such as MHN, Medicare, employer-sponsored plans, private health insurance, and ACA/Marketplace health insurance plans, etc., if applicable.
6. Clients who have served in the United States military may be eligible for health care services through the VA.
7. Uninsured clients who wish to access RW Part B Program substance abuse assistance must see a contracted provider.
8. Privately insured clients may receive assistance with co-pays for eligible RW Part B Program services.

PROCEDURE:

1. Case Managers must make an "HSI - Substance Abuse Treatment Services" service referral for uninsured clients or "HSI – Substance Abuse Treatment Services Co-Pays" service referral for insured clients into the electronic client database.
2. The new service referral should be submitted in "1RFR" status. If the client already has an active service referral for any service, adding a new referral at "1RFR" status is unnecessary. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
4. The DHSS Benefits Administrator will review the service referral to ensure all documentation has been added. If approved, the service referral status will be changed to "8ENR" to enroll the client in RW Part B Outstate services.
5. Case Managers must enter all health insurance coverage information, if applicable. (HIV Case Management Data Rules)
6. Providers, Case Managers, or clients must submit a copy of the provider claim form and EOB to the DHSS Benefits Administrator to be paid for allowable substance abuse services.

DOCUMENTATION:

1. Provider claim form
2. EOB
3. Private insurance member card, if applicable
4. Other documentation, as requested by DHSS or DHSS Benefits Administrator

SUMMARY:

MO RW Part B Program outstate support services are reserved for eligible clients in the Outstate (Central, Northwest, Southeast, and Southwest) regions of MO. Support Services include Emergency Financial Assistance, Exception Requests, and Transportation assistance.

POLICY:

See individual subsections for applicable policies.

PROCEDURE:

See individual subsections for applicable procedures.

DOCUMENTATION:

See individual subsections for applicable documentation.

SUMMARY:

Emergency Financial Assistance (EFA) is an emergency financial resource available to RW Part B qualified individuals who have an emergency need. EFA is meant to provide short-term assistance for emergency expenses related to housing costs (e.g., utility shut-off, rental eviction, or temporary emergency housing). EFA differs from an Exception Request (Section 6.2). An exception request includes services, individual client circumstances, or eligibility that fall outside of policy.

POLICY:

1. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for EFA assistance. (HIV Case Management Manual Section 3.0)
2. Outstate Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. EFA is intended to be applied in situations for which a client requires immediate short-term assistance.
4. EFA **can only be used** to address emergencies that require immediate attention (e.g., utility shut-off, rental eviction, or temporary emergency housing).
5. EFA assistance is available for a maximum of three months per program year (April 1st thru March 31st) per client.
6. EFA requests must be reviewed and approved by the appropriate case management supervisor and Regional Supervisor/QSM prior to submitting to the DHSS Benefits Administrator.
7. There is no guarantee that an EFA request will be approved. EFA requests for Outstate Services, which have been denied by the DHSS Benefits Administrator, will be forwarded to the DHSS HIV Support Services Program Coordinator for follow-up, as needed.
8. EFA payments cannot be directly made to the client or client's family/household. EFA payments will be sent directly to the vendor (e.g., utility company, property owner, etc.).

9. Case managers must assist clients in completing the Budget Plan Worksheet to document the client's need for assistance each time EFA assistance is requested, unless the client requests EFA assistance consecutively. (Appendix A1)
10. Case Managers must complete the Housing/Utility Calculation Worksheet each time EFA assistance is requested. (Appendix A3)
11. EFA documentation must be in the client's name, or the client must be able to prove occupancy at the property (e.g., current lease).
12. All supporting documentation must be submitted before the DHSS Benefits Administrator, or the DHSS HIV Support Services Program Coordinator will review the EFA request.

PROCEDURE:

1. Case Managers must enter an "HSI - Emergency Financial Assistance" service referral.
2. Case Managers must use the EFA request clipping in a "Progress Note" under the HSI - Emergency Financial Assistance referral and include a detailed description of the emergency situation, which explains the EFA request.
3. Case Managers must verify that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
4. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
5. The DHSS Benefits Administrator will send a communicate to the DHSS HIV Support Services Program Coordinator for EFA requests that need further review.
6. DHSS will review EFA requests sent by the DHSS Benefits Administrator and make the final approval or denial determination.
7. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Emergency Financial Assistance Request clipping
2. Budget Plan Worksheet

3. Housing/Utility Assistance Calculation Worksheet
4. Required supporting documents for EFA request:
    a. Utility Shut-Off requests: disconnection/shut-off notice or a letter from the utility company
    b. Rental Eviction requests: letter from the landlord, notice to vacate, W-9, HAV
    c. Temporary Emergency Housing requests: HAV, W-9
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

Exceptions may be granted for services, which exceed or are broader in scope than existing service limits or which fall outside of currently established policy or programmatic guidelines. The following policies and procedures have been established to guide Case Managers through the necessary steps for submitting RW Part B Outstate Services Exception Requests.

POLICY:

1. RW Part B Program services are available based on current funding.
2. Clients must meet the minimum MO HIV Case Management eligibility criteria in order to qualify for an exception request. (HIV Case Management Manual Section 3.0)
3. There is no guarantee that an Exception Request will be approved.
4. Outstate Services Exception Request processes are not intended to be applied in any situation in which the client is in physical jeopardy or requires immediate short-term assistance; therefore, Outstate Services Exception Request processes **cannot** be used to address emergencies.
5. Outstate Services cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
6. The Exception Request Narrative clipping must be completed in the electronic client database to be considered for approval.
7. The Exception Request Narrative clipping must include a list of all considered/explored alternative payer sources.
8. All Exception Requests must be reviewed and approved by the appropriate Case Management Supervisor, Regional Supervisor, and QSM prior to submitting to the DHSS Benefits Administrator.
9. Exception Requests for Outstate Services, which have been denied by the DHSS Benefits Administrator, will be forwarded to the DHSS HIV Support Services Program Coordinator for follow-up, as needed.
10. All documentation that would support the need for an Exception Request must be submitted before the DHSS Benefits Administrator, or the DHSS HIV Support Services Program Coordinator will review the exception request.

PROCEDURE:

1. Case Managers must select the appropriate service referral (listed below) for which the exception is being requested and resubmit the service referral in "2SRR" status.
    a. HSI – ADAP Program/Medications
    b. HSI – Ambulatory/Outpatient Medical Care
    c. HSI – Ambulatory/Outpatient Medical Care Co-pays
    d. HSI – Dental
    e. HSI – Dental Co-pays
    f. HSI – Health Insurance Continuation
    g. HSI – Housing Srvs/Hopwa/Mortgage Asst
    h. HSI – Housing Srvs/HOPWA/Rental Subsidy
    i. HSI – Housing Srvs/RW/Rental Subsidy
    j. HSI – Housing Srvs/RW/Deposit Services
    k. HSI – Mental Health Counseling
    l. HSI – Mental Health Counseling Co-pays
    m. HSI – Spenddown/Ticket to Work Assistance
    n. HSI – Substance Abuse Treatment Services
    o. HSI – Substance Abuse Treatment Services Co-pays
    p. HSI – Transportation
    q. HSI – Utilities
    r. HSI – Utility Deposit
2. Case Managers must enter a new Exception Request Narrative clipping in the Progress Notes section of the appropriate service referral in the electronic client database.
3. Case Managers must include a detailed description as part of the Exception Request explaining all barriers or negative health outcomes that the client may face if the Exception Request is not approved.
4. Case Managers must verify that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
5. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.

6. The DHSS Benefits Administrator will review the service referral to ensure all documentation has been added. If approved, the service referral status will be changed to "8ENR" to enroll the client in RW Part B Outstate services.
7. The DHSS Benefits Administrator will send a communicate to the DHSS HIV Support Services Program Coordinator for Exception Requests that need further review.
8. DHSS will review the Exception Requests sent by the DHSS Benefits Administrator and make the final approval or denial determination.
9. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Exception Request Narrative clipping
2. Budget Plan Worksheet
3. Documents supporting request
4. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

RW Part B Program transportation assistance helps eligible clients gain access to HIV medical appointments and other eligible services in order to prevent barriers to care when no other payer sources are available.

POLICY:

1. RW Part B Program services are available based on current funding.
2. Clients who request RW Part B Program transportation assistance must meet the minimum MO HIV Case Management eligibility criteria and be actively enrolled in RW Part B Case Management in order to qualify for transportation assistance. (HIV Case Management Manual Section 3.0)
3. Clients are eligible for mileage reimbursement for travel to:
    a. community or advocacy agencies;
    b. public assistance agencies to apply for benefits such as food stamps, disability, housing, VA services, etc.;
    c. employment or career center appointments;
    d. case management appointments;
    e. probation and parole visits;
    f. medical appointments;
    g. mental health appointments;
    h. substance use disorder treatment appointments; and
    i. pharmacies for medication pickups.
4. The RW Part B Program cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
5. Clients who are actively enrolled in MHN must access MHN Non-Emergency Medical Transportation (NEMT) services before RW Part B transportation assistance will be approved.
6. Clients who have not met their monthly MHN Spenddown requirement are not considered MHN active and may be eligible for RW Part B transportation assistance.

7. All transportation-related information must be documented in the client's ISP before submitting RW Part B transportation assistance request(s).
8. All sections on the Transportation Request Form must be completed and signed by the client and Case Manager or verified by phone by the Case Manager to be considered for reimbursement. (Appendix A3)
9. All client's medical transportation requests for the month should be submitted on one form.
10. RW Part B Program transportation assistance will only authorize one round-trip reimbursement, even if there are multiple appointments within the same day.
11. RW Part B Program transportation assistance will not authorize payment for more than one reimbursement request per calendar month.
12. RW Part B Program transportation assistance will not provide reimbursement for mileage, which exceeds the number of estimated "direct route" miles as reflected on mileage estimation websites such as MapQuest, Google Maps, etc.
13. RW Part B Program transportation assistance mileage reimbursement rates are $.43 cents per mile.
14. Clients will be reimbursed up to $200.00 per month.
15. Case Managers must assist clients in completing the Budget Plan Worksheet to document the client's need for transportation assistance unless it has been completed within the past six months. (Appendix A1)
16. Requests for mileage reimbursement must be submitted to the DHSS Benefits Administrator by the 15th of the following month for eligible transportation expenses.

MILE REIMBURSEMENT DOCUMENTATION:

1. Transportation Request Form
2. Budget Plan Worksheet
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

BUS PASS POLICY:

1. Clients are eligible to receive bus passes to travel to medical, social support, and essential service appointments, where available.

2. Case Managers must assist clients in completing the Budget Plan Worksheet to document the client's need for transportation assistance, unless it has been completed within the past six months. (Appendix A1)
3. RW Part B Program transportation assistance will only provide assistance with bus passes if the client does not have access to private transportation.
4. Public transportation agencies, which provide bus services, must have a current contract with the DHSS Benefits Administrator.
5. Case management agencies may purchase monthly bus passes for distribution to clients if the transportation agency does not have a contract with the DHSS Benefits Administrator.
6. RW Part B Program contracted Case Management agencies may seek reimbursement for bus pass purchases, if appropriate documentation of the purchase is submitted by invoice to the DHSS Benefits Administrator.

BUS PASS DOCUMENTATION:

1. Budget Plan Worksheet
2. DHSS or the DHSS Benefits Administrator may request additional information or documentation to ensure RW Part B Program requirements are met.

PROCEDURE:

1. Case Managers must enter an "HSI – Transportation" service referral.
2. The new service referral should be submitted in "1RFR" status. If the client already has an active service referral for any service, adding a new referral at "1RFR" status is unnecessary. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
4. The DHSS Benefits Administrator will review the service referral to ensure all documentation has been added. If approved, the service referral status will be changed to "8ENR" to enroll the client in RW Part B Outstate services.
5. The "HSI – Transportation" service referral must have an end date that does not exceed the client's Case Management service referral.

6. Case Managers must ensure that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
7. Case Managers must update the "FINANCIAL – Transportation" barrier to care in the client's "Service Plan" module each month that assistance is requested using the "Transportation" clipping in the "Progress Note" section to document why the client is requesting assistance.
8. The DHSS Benefits Administrator will enter the appropriate transportation assistance encounter to document the payment into the electronic client database once the request has been approved.
9. Clients must return any uncashed RW Part B Program transportation-related reimbursement checks to the DHSS Benefits Administrator.
10. Case Managers must send a communicate to the DHSS Benefits Administrator for each month of requested services.
11. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Transportation Request Form
2. Budget Plan Worksheet
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

MO RW Part B Program housing services are reserved for eligible clients in the Outstate (Central, Northwest, Southeast, and Southwest) regions of MO. Housing services policies and procedures outline requirements for documentation and Federal guidelines to access housing services. Housing services include Housing Deposit; Utility Deposit; Short-Term Rent, Mortgage, and Utility (STRMU); and Tenant-Based Rental Assistance (TBRA). This section also includes policies and procedures regarding TBRA Waitlists.

POLICY:

See individual subsections for applicable policies.

PROCEDURE:

See individual subsections for applicable procedures.

DOCUMENTATION:

See individual subsections for applicable documentation.

SUMMARY:

The RW Part B Program housing assistance has established the following policies to outline the minimum requirements that a rental lease must meet for clients to be eligible to receive assistance for a property. Lease standards are in accordance with federal housing guidelines established in the HOPWA Rental Assistance Guidebook by the Department of Housing and Urban Development (HUD).

POLICY:

1. There is no guarantee that a lease will be approved for either full or partial assistance. Leases must be reviewed by DHSS or the DHSS Benefits Administrator to determine if the lease meets minimum RW Part B Program housing assistance requirements.
2. Leases must be typed. Standardized leases with handwritten rent, deposit, and lease terms are acceptable. However, leases that are entirely handwritten will not be accepted.
3. All leases must be current. The lease must include an expiration or end date that has not passed, or it must include language which indicates that the lease automatically renews or converts to a month-to-month agreement.
4. The lease must include the name of a person or company who is considered the landlord of the property.
5. The RW Part B Program housing assistance cannot provide assistance for leases that include co-signers.
6. The lease must include the legal names of all occupants that will be living in the property.
7. Leases that have been approved by the RW Part B Program housing assistance must be signed by both the tenant (client) and landlord prior to receiving assistance.
8. The lease must specify the monthly rental amount.
9. The lease must specify the amount of the rental deposit.
10. The lease cannot contain language stating “first and last month’s rent.”
11. The lease must include specific details regarding which utilities are to be paid by the landlord and which are to be paid for by the tenant.

12. Leases that indicate amenities such as appliance rental, cable, internet expenses, etc., must separate out the monthly cost of the amenity if they are included in the monthly cost of the rent.
    a. Per HUD guidelines, cable and internet expenses are not allowable. If cable and internet is included in the rent amount, $70 must be deducted to cover cable and internet expenses.
13. Pet expenses included as a deposit or as part of the lease will not be covered.
14. The amount of amenity costs must be deducted from rent calculations.
15. The lease may include a list of tenant rights and responsibilities. If a lease does not include tenant rights and responsibilities, Case Managers may provide the client with information on MO Landlord-Tenant Laws upon request.
16. The lease must include language that identifies the landlord's responsibility for the maintenance and services of the property.
17. The lease must include the condition(s) necessary for eviction.
18. The lease must include language that prohibits discrimination.
19. The lease must **not** include any of the following provisions:
    a. **Agreement to be Sued.** This agreement states that the tenant agrees to be sued, to admit guilt, or to a judgement in favor of the owner/landlord brought in connection with the lease.
    b. **Treatment of Property**. This agreement states that the owner may take, hold, or sell personal property of the household members without notice to the tenant and a court decision on the rights of the parties. This prohibition does not apply to an agreement by the tenant concerning the disposition of personal property remaining in the property after the tenant has moved out of the property. The owner may dispose of this personal property in accordance with state law.
    c. **Excusing Owner from Responsibility.** This agreement states that the tenant agrees to not hold the owner/landlord, or their agents responsible for any action or failure to act, whether intentional or negligent.
    d. **Waiver of Notice**. This agreement states that the owner may institute a lawsuit without notice to the tenant.

e. **Waiver of Legal Proceedings**. This agreement states that the owner may evict the tent or household members without instituting a civil court proceeding in which the tenant has the opportunity to present a defense or before a court decision is made on the rights of both parties.

f. **Tenant Chargeable with Cost of Legal Actions regardless of Outcome.** This agreement states that the tenant agrees to pay the attorney's fees and/or other legal costs even if the tenant wins in a court proceeding against the owner. Note: the tenant may be obligated to pay attorney's fees and/or other legal costs if the tenant loses in a court proceeding.

g. **Payment of Additional Rent or Fees to the Landlord.** This agreement states that the tenant agrees to pay additional rent or fees to the landlord out of pocket once occupancy takes place.

20. Case Managers may complete the optional Lease Standards Checklist prior to submitting requests for assistance to ensure the lease meets the minimum RW Part B Program housing assistance standards. (Appendix A4)
21. DHSS or the DHSS Benefits Administrator may request additional information at any time before or after a client's enrollment in any Outstate Service.
22. If landlords do not have a lease agreement that includes all necessary requirements, landlords may use the HUD sample lease located on page 148 of the HOPWA Rental Assistance Guidebook.

PROCEDURE:

1. Case Managers must ensure that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
2. The DHSS HIV Support Services Coordinator or the DHSS Benefits Administrator must review and approve the lease prior to the client being eligible to receive assistance for the rental property.
3. The DHSS HIV Support Services Coordinator or DHSS Benefits Administrator will request additional clarification from the Case Manager if necessary.

DOCUMENTATION:

1. Lease
2. Optional Lease Standards Checklist
3. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

RW Part B Program housing deposit assistance helps provide access to rent security deposits when there are no other available payer sources.

POLICY:

1. RW Part B Program services are available based on current funding.
2. Clients who request RW Part B Program housing assistance must meet the minimum MO HIV Case Management eligibility criteria and be actively enrolled in RW Part B Case Management in order to qualify for housing deposit assistance. (HIV Case Management Manual Section 3.0)
3. RW Part B service referrals must be in "8ENR" status when services are rendered if requesting assistance.
4. The RW Part B Program cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
5. The maximum allowable amount for housing deposit assistance cannot exceed the cost of one month's rent. Housing deposit assistance is allowed one-time per the client's lifetime.
6. Leases must be signed by all parties prior to a housing deposit check being sent to the landlord.
7. Clients who share housing with individuals who do not meet the current HIV Case Management definition of a household member or dependent will only be eligible for their portion of the deposit.
8. Deposit assistance will not be provided on behalf of an eligible client who leases or rents from a family member or to a business managed or owned by a family member.
9. Housing deposit assistance may not be combined with, or received at the same time as any other federally funded community based housing and utility programs including, but not limited to:
    a. Section 8,
    b. Section 811,
    c. Shelter Plus Care,
    d. OMO Next Step, and

e. Other HUD housing programs, etc.

10. The "Social Supports" module must list everyone living in the home and have all *Support information* and *Demographic information* for spouse and dependents as outlined in the HIV Case Management Manual (Section 3.2.3), or it will be considered incomplete and returned to the Case Manager. For non-spouse or dependent household members, only their first and last name is required.
10. The "Demographics" module "Household Size" must match the number of individuals living in the home regardless of their relationship to the client.
11. The "Demographics" module "Dependents" must match the number of dependents listed in the "Social Supports" module.
12. Case Managers must assist clients in completing the Budget Plan Worksheet to document the client's need for housing deposit assistance, unless it has been completed within the past six months or if there have been changes with the client's income and expenses.
13. Leases must meet all requirements outlined in Section 7.1 – Lease Standards.
14. A current lease agreement showing the required deposit amount must be submitted for rental deposits.
15. Case Managers must complete the Housing/Utility Assistance Calculation Worksheet upon request for assistance and at minimum annually or upon request by the client, DHSS, or the DHSS Benefits Administrator. (Appendix A3)
16. The most current W-9 IRS-Request for Taxpayer Identification Number and Certification must be completed by the landlord upon request assistance.
17. The Housing Assistance Verification (HAV) Form must be completed by the landlord upon request for housing deposit assistance. (Appendix A5)
18. DHSS or the DHSS Benefits Administrator may request additional information at any time before or after a client's enrollment in any Outstate Service.

PROCEDURE:

1. Case Managers must enter an "HSI – Housing Srvs/RW/Deposit Services" service referral for the month of service requested.

2. The new service referral should be submitted in "1RFR" status. If the client already has an active "HSI – Housing Srvs/RW/Deposit Services" service referral, adding a new referral at "1RFR" status is not necessary. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will change the service referral status to "6CSM" and send a communicate to the Case Manager if further information is needed.
4. The DHSS Benefits Administrator will review the service referral and change the referral status to "7CLS" once deposit assistance is approved.
5. Case Managers must ensure that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
6. Case Managers must inform clients that they are allowed a one-time per the client's lifetime deposit assistance.
7. Case Managers must inform clients that deposit assistance funds must be returned to the program or transferred to the next housing unit if a deposit refund is issued.
8. Case Managers must send the DHSS Benefits Administrator a communicate if any additional information regarding the referral is entered into the electronic client database.
9. The DHSS Benefits Administrator will send a communicate to the DHSS HIV Support Services Program Coordinator for housing deposit requests that need further review.
10. DHSS will review the utility deposit requests sent by the DHSS Benefits Administrator and make the final approval or denial determination.
11. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Housing/Utility Assistance Calculation Worksheet
2. Budget Plan Worksheet
3. Current lease agreement
4. W-9 IRS-Request for Taxpayer Identification Number and Certification
5. HAV form
6. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

RW Part B Program utility deposit assistance helps provide access to utility security deposits when there are no other available payer sources.

POLICY:

1. RW Part B Program services are available based on current funding.
2. Clients who request RW Part B Program utility deposit assistance must meet the minimum MO HIV Case Management eligibility criteria and be actively enrolled in RW Part B Case Management in order to qualify for housing and utility deposit assistance. (HIV Case Management Manual Section 3.0)
3. The RW Part B Program cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
4. RW Part B service referrals must be in "8ENR" status when services are rendered if requesting assistance.
5. Utility deposit assistance is allowed one-time per the client's lifetime.
6. Utility deposit assistance may not be combined with, or received at the same time as any other federally funded community based housing and utility assistance programs including, but not limited to:
    a. Section 8,
    b. Section 811,
    c. Shelter Plus Care,
    d. OMO Next Step funding,
    e. LIHEAP, or
    f. Other HUD assistance programs.
7. The "Social Supports" module must list everyone living in the home and have all *Support information* and *Demographic information* for spouse and dependents as outlined in the HIV Case Management Manual (Section 3.2.3), or it will be considered incomplete and returned to the Case Manager. For non-spouse or dependent household members, only their first and last name is required.

8. The "Demographics" module "Household Size" must match the number of individuals living in the home regardless of their relationship to the client.
9. The "Demographics" module "Dependents" must match the number of dependents listed in the "Social Supports" module.
10. Case Managers must assist clients in completing the Budget Plan Worksheet to document the client's need for utility deposit assistance, unless it has been completed within the past six months or if there have been changes with the client's income and expenses.
11. A current utility statement that shows the required utility deposit amount must be submitted prior to receiving utility deposit assistance.
12. The client or client's spouse's name must be on the utility statement.
13. A current lease agreement, statement for the deposit, or letter from the utility company is required to provide proof that the client lives in the unit and is responsible for payment of utilities.
14. Clients who share housing with individuals who do not meet the current HIV Case Management definition of a household member or dependent will only be eligible for their portion of the utility costs.
15. Case Managers must complete the Housing/Utility Assistance Calculation Worksheet upon request for assistance and at minimum annually or upon request by the client, DHSS, or the DHSS Benefits Administrator. (Appendix A3)
16. DHSS or the DHSS Benefits Administrator may request additional information at any time before or after a client's enrollment in any Outstate Service.

PROCEDURE:

1. Case Managers must enter an "HSI –Utility Deposit" service referral for the month of service requested.
2. The new service referral should be submitted in "1RFR" status. If the client already has an active "HSI –Utility Deposit" service referral, adding a new referral at "1RFR" status is not necessary. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will change the service referral status to "6CSM" and send a communicate to the Case Manager if further information is needed.

4. The DHSS Benefits Administrator will review the service referral and change the referral status to "7CLS" once deposit assistance is approved.
5. Case Managers must ensure that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
6. The DHSS Benefits Administrator will send a communicate to the DHSS HIV Support Services Program Coordinator for utility deposit requests that need further review.
7. DHSS will review the utility deposit requests sent by the DHSS Benefits Administrator and make the final approval or denial determination.
8. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Housing/Utility Assistance Calculation Worksheet
2. Budget Plan Worksheet
3. Current lease agreement
4. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

RW Part B Short-Term Rent, Mortgage, and Utility (STRMU) assistance helps provide access to rent, mortgage, or utility assistance for clients who have a short-term financial issue (i.e., sudden loss of income or employment due to health or household composition, sudden extraordinary and unexpected health care costs, etc.). STRMU assistance is provided for a limited time to support stable housing and reduce the risk of homelessness.

POLICY:

1. Clients who request RW Part B Program STRMU assistance must meet the minimum MO HIV Case Management eligibility criteria and be actively enrolled in RW Part B Case Management in order to qualify for STRMU assistance. (HIV Case Management Manual Section 3.0)
2. The RW Part B Program cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. STRMU assistance is only available for clients who are currently housed and have an income at or below 125% of the FPL.
4. Homeless individuals are not eligible for STRMU due to the limited timeframe of the program. (Section 6.1).
5. STRMU assistance is available for a maximum of three months per program year (April 1st thru March 31st) per client.
6. STRMU assistance may be used up to the amount determined on the Housing/Utility Assistance Calculation Worksheet for the following (Appendix A3):
    a. Rent,
    b. Mortgage,
    c. Electricity,
    d. Water,
    e. Sewer,
    f. Trash
    g. Natural gas,
    h. Propane, or
    i. Wood

7. STRMU assistance for propane and wood may be combined into one service referral for three months of assistance unless the three months extends past the current Case Management service referral date.
8. Escrow amounts for taxes and homeowner's insurance that are figured into the mortgage payment are eligible to receive STRMU.
9. Mobile home STRMU assistance is allowable.
10. STRMU assistance cannot be used for the following expenses:
    a. Security deposits
    b. First month's rent (Section 6.1)
    c. Moving assistance
    d. Household supplies and furnishings
    e. Telephone/cellphone expenses
    f. Pet expenses
    g. Internet or cable expenses
    h. Credit card debt for expenditures of a personal nature (vacations, holiday gifts, home furnishings, personal grooming, pets, etc.)
    i. Automobile repairs or payments (unless essential for regular employment or full-time education, or where public transportation is inadequate)
    j. Payment of child support or alimony
    k. Tickets, fines, or restitution payments
    l. Personal loans or financial obligations which are not related to allowable housing services
11. STRMU assistance may be accessed independently or simultaneously for rent, mortgage, or utility payments.
12. STRMU assistance must be requested in separate referrals and only if the client requests it.
13. STRMU requests must include detailed descriptions of why assistance is needed and the amount to be paid to each provider.
14. Leases must meet standards outlined in Outstate Manual Section 7.1.
15. Case Managers must collaborate with clients to create an ISP for each STRMU request.

16. The ISP must include a "FINANCIAL – Housing/Living Situation" barrier to care with a Progress Note with specific, measurable, and attainable goals that include:
    a. **Housing -** Steps for the client to identify, obtain, and maintain stable housing, which may also include future-oriented housing goals;
    b. **Income** – Goals related to obtaining or maintaining earned income or benefits that will support the client's housing stability;
    c. **Education/Skills** – Goals to seek training or preparation for employment
    d. **Access to Care** – Goals in this area should ensure ongoing service coordination and measurement of client health outcomes with linkages to RW Care Act services, primary HIV/Acquired Immune Deficiency Syndrome (AIDS) medical care, VA medical benefits, and other services, as well as insurance or medical assistance, mental health treatment, or other treatment needs identified. Achievement of these goals will address the Housing Opportunities for Persons with AIDS (HOPWA) program's care and support objectives.
    e. **Other Supportive Services** – Goals to identify other support services the client may need, such as child support, independent living skills, or connection to family/social support networks.
17. Clients must provide a current lease agreement, mortgage statement, or utility bill that shows they are legally responsible for the rent, mortgage, or utility payment.
18. To ensure payment can be made, the Case Manager must upload a complete, legible, and current copy of the lease, mortgage statement, and/or utility statement that includes:
    a. The name, address, and phone number of the landlord, lender, or utility company; and
    b. The name, address, and account number of the client
19. To be considered current, mortgage and utility statements must not be older than 30 days.
20. Case Managers must assist clients in completing the Budget Plan Worksheet to document the client's need each time STRMU assistance is requested unless the client requests STRMU for three consecutive months. (Appendix A1)
21. Case Managers must complete the Housing/Utility Assistance Calculation Worksheet each time STRMU assistance is requested. (Appendix A3)

22. Inspections are not required for STRMU assistance. However, the client must attest to their home meeting minimum habitable standards outlined on the Housing Quality Standards Inspection form. (Appendix A7)
23. Mortgage assistance can only be provided if the mortgage contract or deed lists the client and/or the client's spouse. If individuals other than the client's spouse are listed on the mortgage contract or deed, the property is not eligible for STRMU.
24. Mobile homes with wheels, capable of being relocated, are considered personal property and therefore are not eligible for STRMU.
25. Monthly mobile home payments and pad/lot rent assistance can be provided if the mobile home meets the following criteria:
    a. Is permanently attached to the ground with utility and sewer connections and compliant with local guidelines.
    b. Must be located on land that is owned by the mobile homeowner or on land that has a current lease with the mobile homeowner (e.g., mobile home park)
26. Each individual expense associated with mobile homes is counted separately toward the three-month STRMU limit.
27. STRMU can be used to assist clients who live with an adult family member if they are included on the lease as a tenant and (Appendix C1):
    a. The entire household income meets HUD low-income eligibility guidelines for MO and is being assisted by STRMU; or
    b. The client is renting a property from an adult family, and a "reasonable accommodation" is determined necessary for the client. The family's income is not included in calculations for the client's assistance (24 CFR 82.306(d))
28. A "Reasonable Accommodation" is defined as a client who is unable to complete activities of daily living (ADLs) such as preparation of meals, laundry, housekeeping, bathing, dressing, ambulation, transfer, and transportation to medically related services. Examples of a "Reasonable Accommodation" include:
    a. Being determined disabled by MHN or Social Security;
    b. Having a score of two or higher on the 2.0 MCMAT under the Activities of Daily Living; and/or

c. A physician signed statement that the client requires assistance

29. Clients who request a reasonable accommodation but have not been determined to be disabled by MHN or Social Security must have both a Family Verification of Demonstrated Need and a Physician Verification of Demonstrated Need form completed prior to the STRMU request. (Appendix A16 and A17)
30. The W-9 IRS-Request for Taxpayer Identification Number and Certification must be completed by the landlord (rental assistance only) upon request for assistance unless the form has been completed by the same landlord within the past year.
31. The W-9 Request for Taxpayer Identification Number and Certification must be completed by the mortgage lender if the lender is not a financial institution or bank upon request for assistance unless the form has been completed by the same mortgage lender within the past year.
32. The HAV (rent only) must be completed by the landlord upon request for assistance unless the form has been completed by the same landlord within the past year. (Appendix A10)
33. Clients who apply for STRMU assistance in more than one program year must apply for all available community-based housing and utility assistance programs prior to requesting assistance for housing. (Appendix A5)
34. Any client at or below 135% of the FPL should have an annual application on file each year with any available community-based housing and utility assistance programs.
35. The Case Manager must use the Public Housing Verification Worksheet in the event that the client is not able to obtain written verification of application or eligibility for other housing or utility assistance programs. (Appendix A11)
36. The client will be responsible for any amount over their eligible assistance amount reflected on the Housing/Utility Calculation Worksheet. (Appendix A3)
37. Clients must read and sign the Housing Related Client Rights, and Responsibilities form upon request for STRMU assistance, at minimum annually, or upon request by DHSS or the DHSS Benefits Administrator. (Appendix A12)
38. The “Social Supports” module must list everyone living in the home and have all Support information and Demographic information for spouse and dependents as outlined in the HIV Case Management Manual (Section 3.2.3) or it will be

considered incomplete and returned to the Case Manager. For non-spouse or dependent household members, only their first and last name is required.

39. The "Demographics" module "Household Size" must match the number of individuals living in the home regardless of their relationship to the client.
40. The "Demographics" module "Dependents" must match the number of dependents listed in the "Social Supports" module.
41. The "Housing" module must reflect the residence for which the client is requesting STRMU assistance.
42. STRMU assistance may not be combined with or received at the same time as any other federally funded community-based housing and utility assistance programs, including, but not limited to:
    a. Section 8,
    b. Section 811,
    c. Shelter Plus Care,
    d. HUD,
    e. HUD Tax Credit,
    f. LIHEAP, or
    g. OMO Next Step funding.

PROCEDURE:

1. Case Managers must enter the appropriate housing-related service referral for the month of requested service(s).
    a. "HSI – Housing Srvs/RW/Rental Subsidy" (for rental assistance)
    b. "HSI – Utilities" (for utility assistance)
    c. "HSI – Housing Srvs/HOPWA/Mortgage Asst." (for mortgage assistance)
2. The new service referral(s) should be submitted in "1RFR" status. If the client already has an active service referral (see above) for the same type of requested housing-related assistance, a new referral is not necessary. (HIV Case Management Data Rules)
3. Case Managers must verify that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
4. Case Managers must ensure that the "Housing" module reflects the client's current address.

5. Case Managers must complete the "Social Supports" module according to the HIV Case Management Manual (Section 3.2.3). For non-spouse or dependent household members, only their first and last name is required.
6. The DHSS Benefits Administrator will change the service referral status to "6CSM" if Case Manager follow-up is needed.
7. The DHSS Benefits Administrator will review the STRMU request and change the referral status to "8ENR" once STRMU assistance is approved.
8. The DHSS Benefits Administrator will send a communicate to the DHSS HIV Support Services Program Coordinator for STRMU requests that need further review.
9. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Budget Plan Worksheet
2. Current lease agreement, if applicable
3. Mortgage statement, if applicable
4. Utility bill, if applicable
5. Housing/Utility Assistance Calculation Worksheet
6. HAV form (rent only)
7. W-9 IRS-Request for Taxpayer Identification Number and Certification, if applicable
8. Housing Quality Standards Inspection form
9. Housing Related Client Rights and Responsibilities
10. Proof of applications for to all available public or community-based housing and utility programs, if available
11. Public Housing Verification Worksheet, if applicable
12. Family Verification of Demonstrated Need form, if applicable
13. Physician Verification of Demonstrated Need form, if applicable
14. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The RW Part B Long-Term Tenant-Based Rental Assistance (TBRA) program helps provide access to stable housing to reduce the risk of homelessness. TBRA provides clients housing assistance until they are able to receive permanent community-based housing assistance or until they able to provide stable housing without assistance.

POLICY:

1. Clients who request RW Part B TBRA must meet the minimum MO HIV Case Management eligibility criteria and be actively enrolled in RW Part B Case Management to qualify for assistance. (HIV Case Management Manual Section 3.0)
2. The RW Part B Program cannot pay for any item or service for which payment has been made or can reasonably be expected to be made by another payer source.
3. TBRA assistance may be used to pay rent, electricity, or heating costs up to the amount calculated on the Housing/Utility Calculation Worksheet. (Appendix A3)
4. RW Part B TBRA assistance cannot be used for mortgage assistance.
5. TBRA will only be paid one time per month.
6. Leases must meet standards outlined in Outstate Manual Section 7.1.
7. In order for rent to be paid on time, documentation should be entered 15 days prior to the expiration of the current service referral.
8. If the client is being legally evicted, the eviction notice must be submitted to the Case Manager.
9. Clients must apply for all available housing assistance programs within 30 days of requesting assistance for housing and verification must be uploaded into the electronic client database.
10. Clients must maintain an active application with all available public housing assistance programs.
11. If public housing assistance programs are closed at the time the client request TBRA assistance, the client must check back with the housing assistance programs prior to the TBRA six month update. If the housing program is accepting applications, the client must apply at that time.

12. The Case Manager must use the Public Housing Verification Worksheet in the event that the client is not able to obtain written verification of application or eligibility for other housing or utility assistance programs. (Appendix A11)
13. Clients who fail to apply for available housing assistance programs may experience an interruption in their TBRA assistance until documentation of application has been uploaded in the electronic client database.
14. If the client has no income, the Housing/Utility Calculation Worksheet eligible amount must be equal to or greater than the cost of the rent and utilities if the rent amount is equal to or below current HUD Fair Market Housing (FMR) standards and rent reasonableness guidelines. (Section 7.6)
15. The ISP must be completed every six months to document action steps for the client to secure income or reduce expenses.
16. The ISP must include a "FINANCIAL – Housing/Living Situation" barrier to care with a Progress Note with specific, measurable, and attainable goals that include:
    a. **Housing -** Steps for the client to identify, obtain, and maintain stable housing, which may also include future-oriented housing goals;
    b. **Income** – Goals related to obtaining or maintaining earned income or benefits that will support the client's housing stability;
    c. **Education/Skills** – Goals to seek training or preparation for employment
    d. **Access to Care** – Goals in this area should ensure ongoing service coordination and measurement of client health outcomes with linkages to Ryan White Care Act services, primary HIV/AIDS medical care, VA medical benefits and other services, as well as insurance or medical assistance, mental health treatment, or other treatment needs identified. Achievement of these goals will address the HOPWA program's care and support objectives.
    e. **Other Supportive Services** – Goals to identify other support services the client may needed, such as child support, independent living skills, or connection to family/social support networks.
17. If any lease includes an incentive for early payment of rent, the higher amount will be paid.

18. The HAV must be completed by the landlord upon request for assistance and at minimum annually, or with any changes. (Appendix A5)
19. The client will be responsible for any amount over their eligible assistance amount reflected on the Housing/Utility Calculation Worksheet. (Appendix A3)
20. Clients with no income must have a signed Income Attestation Form. (HIV Case Management Manual Section 3.2.3)
21. Clients cannot typically request an exception for assistance with their portion rent. Information regarding emergency situations are outlined in Outstate Manual Section 6.1.
22. Clients who fail to pay their portion of rent are required to submit documentation once payment(s) have been made to continue receiving TBRA assistance.
23. The "Social Supports" module must list everyone living in the home and have all Support information and Demographic information for spouse and dependents as outlined in the HIV Case Management Manual (Section 3.2.3) or it will be considered incomplete and returned to the Case Manager. For non-spouse or dependent household members only their first and last name is required.
24. The "Demographics" module "Household Size" must match the number of individuals living in the home regardless of their relationship to the client.
25. The "Demographics" module "Dependents" must match the number of dependents listed in the "Social Supports" module. Pet expenses are not allowable.
26. TBRA assistance may not be combined with, or received at the same time as any other federally funded community based housing and utility assistance programs including, but not limited to:
    a. Section 8,
    b. Section 811,
    c. Shelter Plus Care,
    d. HUD,
    e. HUD Tax Credit,
    f. LIHEAP, or
    g. OMO Next Step funding.

27. The property must meet the standards as outlined on the Housing Quality Standards Inspection form. (Appendix A7)
28. Housing inspections must be completed upon request for assistance, moving to a new property, and at minimum annually or upon request by the client, DHSS or the DHSS Benefits Administrator. (Appendix C1)
29. Properties that do not meet standards will not be approved for TBRA assistance. If deficiencies noted during the initial inspection have been reported as corrected, the property must be re-inspected to ensure this.
30. Clients must be provided a copy of the completed Housing Quality Inspection Standards form. (Appendix A7)
31. The DHSS HIV Support Services Coordinator will conduct a rent reasonableness analysis comparing three comparable unassisted properties. (Section 7.6)
32. Case Managers must assist clients in completing the Budget Plan Worksheet to document the client's need for TBRA upon request for assistance, and at minimum annually or upon request by DHSS or the DHSS Benefits Administrator. (Appendix A1)
33. Case Managers must complete the Housing/Utility Assistance Calculation Worksheet upon request for assistance, and at minimum annually or upon request by the client, DHSS or the DHSS Benefits Administrator. (Appendix A3)
34. The W-9 IRS-Request for Taxpayer Identification Number and Certification must be completed by the landlord upon request for assistance unless the form has been completed by the same landlord within the past year.
35. The Housing Assistance Notification (HAN) must be completed by the Case Manager upon request for assistance, at minimum annually, or with any changes to the amount of assistance. (Appendix A6)
36. Case Managers must provide the landlord and client a copy of the completed HAN.
37. Clients must read and sign the Housing Related Client Rights and Responsibilities form upon request for TBRA assistance and at minimum annually or upon request by DHSS or the DHSS Benefits Administrator. (Appendix A12)

38. Case Managers must provide the client with a copy of the signed Housing Related Client Rights and Responsibilities form. (Appendix A12)
39. The Rent Reasonableness Checklist and Certification Form must be completed by the DHSS HIV Support Services Program Coordinator. (Appendix A10)
40. A Lead-Based Paint Disclosure Form must be completed and signed by the property owner and tenant, unless the lease includes a Lead Warning Statement which confirms that the landlord has complied with all Lead-Based Paint requirements prior to approval for TBRA. (Section 7.7)
41. TBRA referrals put on hold for any reason will have a maximum of 30 days to remain open. If the Case Manager has not communicated with the DHSS Benefits Administrator within 30 days, the referral will be closed.
42. Family members of deceased clients receiving TBRA assistance will receive up to three months of TBRA assistance immediately following the client's death.
    a. The amount of TBRA assistance that the client's family will receive will be up to the same dollar amount that the deceased client was receiving prior to their death. Family members cannot request assistance above what the client was receiving.
    b. The Case Manager must notify the DHSS HIV Support Services Program Coordinator and DHSS Benefits Administrator immediately upon notification of client's death.
    c. The Case Manager must provide current contact information for the deceased client's family so that a letter notifying the client's family of DHSS policies can be sent.
    d. The DHSS HIV Support Services Coordinator must notify the family in writing within 10 business days of notification of client's death and scan a copy of the letter to the "Documents" module.
43. To be eligible for shared housing, the property size must be able to accommodate the household size. Each unrelated household should have enough bedrooms to accommodate their family members while not sharing private space with unrelated household members and any local requirements relating to number of bedrooms. (24 CFR 574.310(b)(2)(iii))

44. TBRA assistance cannot be used to assist clients who rent from a family member including a parent, child, grandparent, grandchild, sister, brother, or partner, unless:
    a. the entire household income meets HUD low-income eligibility guidelines for MO and is being assisted by TBRA; or
    b. the client is renting a property/room from the adult family and a "reasonable accommodation" is determined necessary for the client. The family's income is not included in calculations for the client's assistance. (24 CFR 82.306(d))
45. A "Reasonable Accommodation" is modification to allow a client who is unable to complete ADLs such as preparation of meals, laundry, housekeeping, bathing, dressing, ambulation, transfer, and transportation to medically related services live with a family member who will provide necessary assistance. In order to be eligible for a "Reasonable Accommodation," the client must be:
    a. determined disabled by MHN or Social Security;
    b. have a score of two or higher on the 2.0 MCMAT under the Activities of Daily Living; and/or
    c. have a physician signed statement that the client requires assistance.
46. Clients who request a reasonable accommodation but have not been determined to be disabled by MHN or Social Security must have both a Family Verification of Demonstrated Need and a Physician Verification of Demonstrated Need form completed prior to the TBRA request. (Appendix A16 and A17)
47. All documentation to support the client's reasonable accommodation must be uploaded into the electronic client database.
48. Failure to comply with the TBRA "reasonable accommodation" policy will disqualify the client from being eligible to rent from a family member or partner. Any violation of the Demonstrated Need policy, intentional or unintentional, by the client, the family member or, a business managed or owned by a family member, will result in the client becoming ineligible for TBRA assistance until the client finds other allowable living accommodations.

PROCEDURE:

1. Case Managers must enter the "HSI – Housing Svs/HOPWA/Rental Subsidy" service referral in the electronic client database.
2. The service referral(s) should be submitted in "1RFR" status. A new service referral is required for each six month update period and should not extend past the end date of the Case Management service referral. (HIV Case Management Data Rules)
3. The DHSS Benefits Administrator will review the TBRA request and change the referral status to "8ENR" once TBRA assistance is approved.
4. Case Managers must verify that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
5. Case Managers must ensure that the "Housing" module reflects the client's current address.
6. Case Managers will upload documentation every six months that the client has applied for public housing assistance programs in the "Documents" module in the electronic client database.
7. Case Managers must complete the "Social Supports" module, listing everyone living in the home regardless of relationship and have all Support information and Demographic information completed for the client's spouse and dependents.
8. Case Managers must complete an on-site inspection of the property using the Housing Quality Standards Inspection form and upload into the "Documents" module in the electronic client database.
9. Case Managers must provide the client with a copy of the completed Housing Quality Inspection Standards form.
10. Case Manager must send a communicate to notify the DHSS HIV Support Services Program Coordinator and copy the DHSS Benefits Administrator for clients new to TBRA or clients who have been out of TBRA assistance for more than 30 days.
11. The DHSS Benefits Administrator will review all other TBRA requests.

12. The DHSS HIV Support Services Program Coordinator will notify the Case Manager and copy the DHSS Benefits Administrator of the decision to approve or deny the request or if follow-up is needed.
    a. If follow-up is needed, the DHSS HIV Support Services Program Coordinator or the DHSS Benefits Administrator will copy the agency supervisor, QSM, and Director of Case Management.
13. If closing the client from TBRA, the Case Manager must send a communicate to the DHSS HIV Support Services Program Coordinator and DHSS Benefits Administrator stating the reason for closure.
    a. The DHSS Benefits Administrator must select the appropriate "Why Closed" drop-down in the active entry in the "Housing" module and close the client out.
    b. The DHSS Benefits Administrator must change the end date on the current housing service referral to reflect the date TBRA services ended.
14. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Budget Plan Worksheet
2. Current lease agreement
3. W-9 IRS-Request for Taxpayer Identification Number and Certification
4. Housing/Utility Assistance Calculation Worksheet
5. HAV
6. HAN
7. Housing Quality Standards Inspection
8. Rent Reasonableness Checklist
9. Lead-Based Paint Disclosure Form
10. Housing Related Client Rights and Responsibilities
11. Proof of applications available public housing assistance programs
12. Public Housing Verification Worksheet, if applicable
13. Family Verification of Demonstrated Need form, if applicable

14. Physician Verification of Demonstrated Need form, if applicable
15. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

In order to ensure compliance with rent standards and rent reasonableness, the RW Part B Housing Program uses HUD FMR and rent reasonableness guidelines, **whichever is lower**, to determine rent and utility allowance for RW Part B Program housing program clients. Calculations for rent and utility allowance for individuals requesting TBRA assistance must be compliant with HUD Housing regulations. (24 CFR 574.320 (a))

HUD FMR DETERMINATION:

1. The allowable FMR is based on the lesser of the actual number of bedrooms or the number of allowable bedrooms determined by the number of persons living in the housing unit.
2. The number of allowable bedrooms is determined by the number of persons living within the same housing unit.
3. The Housing/Utility Assistance Calculation Worksheet may not calculate accurately for every housing situation. Please consult with the DHSS HIV Support Services Program Coordinator if questions arise. (Appendix A3)
4. If a client lives in a housing unit with a non-family member, the client's share of the rent and/or utilities must be their prorated share of the FMR. (Appendix C1)

FMR Allowable Bedrooms					
Number of persons in a housing unit	1 person	1-2 persons	2-4 persons	3-6 persons	4-8 persons
Number of allowable bedrooms	0 BR	1 BR	2 BR	3 BR	4 BR

FMR POLICY:

1. The most current HUD FMR guide will be used to establish rent standards according to other properties in the same geographic area.
2. The DHSS HIV Support Services Program Coordinator will provide Case Managers with the most current FMR standards in the applicable service area.
3. Rent standards must not be lower than 100% of the most current FMR.

4. Rent standards will be reviewed by the DHSS HIV Support Services Coordinator or Case Managers upon request for assistance, at lease renewal, and annually for all clients receiving RW Part B Program housing assistance.
5. DHSS will consider the rent cost per month and the following utilities when assessing rent standards:
    a. electricity,
    b. fuel (e.g., natural gas, oil),
    c. water,
    d. sewer, and
    e. trash removal.
6. DHSS will **not** consider the following expenses when assessing the rent standards:
    a. telephone,
    b. internet,
    c. cable,
    d. additional expenses for appliances, and
    e. the cost of utilities which are separate from the rent paid to a landlord.
7. The FMR standard analysis must be documented in the client's file in the "Documents" module in the electronic client database.
8. Clients who are already housed in properties with rent that still meet rent standards are eligible to continue receiving assistance at the same rate.
9. If there are changes in rent that are above the FMR, clients will be eligible for assistance up to the allowed FMR.
10. Client documents must be monitored to ensure FMR standards are applied correctly according to other properties in the same geographic area.
11. FMR standard adjustments will be made within 90-days following the release of the new guidelines.
12. If the FMR standard is adjusted down to require more rent to be paid by the client, clients will be given 90-days, at minimum, to secure other housing or adjust their budget to afford the amount over the FMR.

13. Clients with new lease terms or are under lease terms that automatically renew will be given until the end of the current lease term to secure other housing or adjust their budget.
14. Clients with leases that are on a month-to-month basis will be given 90-days to secure other housing or adjust their budget.
15. Clients may request a one-time 90-day extension if additional time is needed to secure new housing due to FMR standard adjustments.
16. Exception Request for paying rent that the client is responsible for above FMR standards will not be allowed.

FMR PROCEDURE:

1. The DHSS HIV Support Services Coordinator will provide Case Managers with the most current HUD FMR standards within 90-days of the annual FMR update.
2. The DHSS HIV Support Services Coordinator will review TBRA client rent amounts to ensure rent meets HUD FMR standards.
3. The DHSS HIV Support Services Coordinator will use the Rent Reasonableness Checklist to review requests and upload the completed checklist into the "Documents" module in the electronic client database. (Appendix A18)
4. The DHSS HIV Support Services Coordinator will send a communicate to notify the Case Manager when a client's rent does not meet FMR standards.
5. The DHSS HIV Support Services Coordinator will contact current TBRA clients by postal mail when their rent no longer meets FMR standards.
6. Case Managers may submit an Exception Request for current TBRA clients whose rent no longer meets HUD FMR standards. (Section 6.2)
7. The DHSS HIV Support Services Coordinator will review FMR Exception Requests.
8. The DHSS HIV Support Services Coordinator will send a communicate to the Case Manager and copy the DHSS Benefits Administrator of the approval or denial.

RENT REASONABLENESS DETERMINATION POLICY

1. Rent being charged for TBRA assisted properties must be considered reasonable according to HUD guidelines.
2. Rent reasonableness must be verified by comparing other comparable properties in the same geographic area using HUD expectations outlined in 24 CFR 982.507(b).
3. DHSS HIV Support Services Coordinator will review properties to determine if they meet rent reasonableness standards.
4. If there is a 5% decrease between the current FMR and the previous year's FMR for a unit size, the RW Part B Program will require that a new rent reasonableness review be conducted.
5. The RW Part B Program may conduct rent reasonableness assessments at any time.
6. Rental assistance will not be determined or increased before verifying that the rent cost meets rent reasonableness standards.
7. Rent reasonableness will consider the previous rent charged for the property and current rent charged for comparable properties by the same landlord and within the same geographic area.
8. If comparable properties are not available within the same geographic area, the rent reasonableness analysis will be completed using similar properties in other complexes or similar geographic areas.
9. Rent for a property must be at or below the same monthly rent costs for at least three comparable properties in the same geographic area.
10. A property that has been determined to be rent reasonable for rent plus utilities must not exceed 10% of the FMR standard (e.g., FMR rate for an area is $500, but rent reasonableness analysis shows that property rent is equal to $510, the property is not over 10% of the FMR and would be allowable).
11. The RW Part B Program cannot assist with rent that is not reasonable and above FMR.
12. The RW Part B Program cannot pay over the amount of rent charged for non-RW clients for comparable properties in the same geographic area.
13. Properties may not be $50 over the amount of rent for comparable properties.

14. If rent is determined to be unreasonable, clients must find a new property that meets rent reasonableness standards or negotiate a lower rent with the landlord.
15. Rent assistance will not be provided for properties that do not meet rent reasonableness standards.
16. Exception Requests will not be allowed to pay any rent that the client is responsible for, which is above rent reasonableness standards.
17. Landlords must provide all rental information regarding rent charged by the landlord for other properties in or on the premises or elsewhere upon request.
18. Landlords who accept TBRA assistance for multi-unit properties (apartments) must verbally attest that the rent to the owner is not more than rent charged by the landlord for comparable unassisted units in or on the premises.
19. Clients must be notified of rent reasonableness standards upon request for TBRA assistance.
20. If the rent reasonableness standard is adjusted down to require more rent to be paid by the client, clients will be given 90-days, at minimum, to secure other housing or adjust their budget to afford the amount over rent reasonableness standards.
21. Clients with new lease terms or are under lease terms that automatically renew will be given until the end of the current lease term to secure other housing or adjust their budget.
22. Clients with leases that are on a month-to-month basis will be given 90-days to secure other housing or adjust their budget.
23. Clients may request a one-time 90-day extension if additional time is needed to secure new housing due to rent reasonableness adjustments.

RENT REASONABLENESS PROCEDURES:

1. The DHSS HIV Support Services Coordinator will conduct an analysis using the Rent Reasonableness Checklist. (Appendix A10)
2. The DHSS HIV Support Services Coordinator will upload the Rent Reasonableness Checklist and supporting verification into the “Documents” module in the electronic client database. (Appendix A10)

3. The DHSS HIV Support Services Coordinator will research and obtain comparable rental information if needed.
4. The DHSS HIV Support Services Coordinator must obtain a verbal attestation that the rent to owner amount is not more than rent charged by the landlord for comparable unassisted properties in or on the premises or elsewhere.
5. The DHSS HIV Support Services Coordinator will record the landlord's verbal attestation on the Rent Reasonableness Checklist. (Appendix A10)
6. Case Managers will advise clients that the property must meet rent reasonableness standards prior to the client receiving TBRA assistance.
7. The DHSS HIV Support Services Coordinator will send a communicate to notify the Case Manager when a client's rent does not meet rent reasonableness standards.
8. The DHSS HIV Support Services Coordinator will contact current TBRA clients by postal mail when their rent no longer meets rent reasonableness standards.
9. Case Managers may submit an Exception Request for current TBRA clients whose rent no longer meets rent reasonableness standards. (Section 6.2)
10. The DHSS HIV Support Services Coordinator will review rent reasonableness Exception Requests.
11. The DHSS HIV Support Services Coordinator will send a communicate to the Case Manager and copy the DHSS Benefits Administrator of the approval or denial.

DOCUMENTATION:

1. Current lease agreement
2. Rent Reasonableness Checklist
3. Rent reasonableness analysis verification
4. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The RW Part B Program has developed the following policies and procedures to ensure that properties supported through TBRA assistance comply with HUD housing quality standards. All properties must be inspected to ensure safe and sanitary conditions and that the property meets local and state housing codes, prior to receiving TBRA assistance.

HOUSING QUALITY STANDARDS INSPECTIONS POLICY:

1. Inspections shall be completed using the Housing Quality Standards Inspection for Long-Term Rent form upon request for assistance, moving to a new property, and at minimum annually or upon request by the client, DHSS or the DHSS Benefits Administrator. (Appendix A8)
2. Housing inspections must include assessment of the following areas (defined in Appendix C1):
    a. **Meets all applicable local codes;**
    b. **Illegal activity observed;**
    c. **Structure and materials;**
    d. **Access**;
    e. **Space and security;**
    f. **Interior air quality;**
    g. **Water supply;**
    h. **Thermal environment;**
    i. **Lighting and electricity;**
    j. **Food preparation and trash disposal**;
    k. **Sanitary condition; and**
    l. **Smoke detectors.**
3. RW Part B Program TBRA assistance cannot be approved until all standards are met.

LEAD-BASED PAINT POLICY:

1. RW Part B Program will ensure assisted properties comply with all State and Federal laws regarding the Lead-Based Poisoning Prevention Act of 1973 and its applicable Code of Federal Regulations (CFR) (24 CFR Part 35, Subpart M) prior to providing TBRA assistance.
2. Case Managers that perform housing quality inspections must complete the on-line HUD Lead-Based Paint Visual Assessment Training. https://apps.hud.gov/offices/lead/training/visualassessment/h00101.htm.
3. Clients must be provided a Lead-Based Paint Disclosure Form and educational materials (i.e. "Protect Your Family from Lead in the Home" pamphlet) for **all** properties constructed prior to 1978. (Appendix A9 and A10)
4. The RW Part B Program will require a Lead-Based Paint Disclosure Form be signed for all properties constructed before 1978 **and** if there is a child under the age of six or pregnant woman residing in the home, unless the lease includes a lead-based paint disclosure statement. (Appendix A9)
5. A Lead-Based Paint Disclosure Form is not required for properties built after 1978.
6. The RW Part B Program will require a lead-based paint visual assessment of any property constructed before 1978 if the following applies:
    a. will have a child under the age of six and/or
    b. a pregnant woman residing in the home.
7. Lead-based paint visual assessments are **not** required for property if the following statements apply:
    a. The property was constructed after 1978;
    b. No child under the age of six or pregnant woman will be residing in the home;
    c. The property is a zero-bedroom or single room occupancy sized unit;
    d. The property has had X-ray or laboratory testing by a certified personnel of all painted surfaces in accordance with HUD regulations and the property has been officially certified to not contain lead-based paint;

e. The property has had all lead-based paint identified and removed in accordance with HUD regulations;
f. The property meets any other exemptions described in 24 CFR 35.115(a); and/or
g. The property has already undergone and passed a visual assessment in the past 12-months due to the client receiving Federal assistance from another program. **Documentation of this assessment is required**.

8. Case Managers who suspect a child less than six years of age has an elevated blood lead level or who may live in a property built before 1978 that has a potential paint hazard, should notify the DHSS HIV Support Services Program Coordinator.

FIRE SAFETY POLICY:

1. The RW Part B Program is required to comply with the Fire Administration Authorization (FAA) Act of 1992 (Act).
2. During the housing quality standards inspection for TBRA, the property must be assessed for compliance with the FAA Act. The following provisions of the FAA Act are applicable to the RW Part B Program:
    a. Multifamily properties that are four or more stories and were constructed after 1994, including properties that are connected to a newly-constructed property, must be equipped with automatic sprinkler systems and hard-wired smoke detectors.
    b. All properties must have at least one hard-wired or battery operated smoke detector located on each level of the property, excluding spaces and unfurnished attics.
3. All smoke detectors must be installed in accordance with and meet the requirements of the National Fire Protection Association Standards (NFPA) 74 or its successor standards. This includes special accommodations for individuals who are hearing impaired.
4. RW Part B Program funds may not be used to install, replace, or repair smoke detectors in any property.

PROCEDURE:

1. Case Managers must inspect properties and complete a Housing Quality Standards Inspection Form.
2. Case Managers must verify that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
3. Case Managers must submit a copy of the completion certificate for the HUD Lead-Based Paint Visual Assessment training by e-mail or fax to the DHSS HIV Support Services Coordinator to be kept on file at DHSS.
4. Case Managers must provide clients a copy of the Lead-Based Paint Disclosure Form and educational materials to all clients who live in a property built prior to 1978.
5. Case Managers must document proof that lead-based paint educational materials were offered to client(s) by checking the appropriate box on:
    a. the Lead-Based Paint Disclosure Form, if applicable, and
    b. the Housing Quality Standards Inspection Form.
6. Case Managers must send a communicate to the DHSS HIV Support Services Program Coordinator if they suspect a child less than 6 years of age has an elevated blood lead level or who lives in a property with a potential paint hazard.
7. The appropriate DHSS staff will report the suspected lead exposure concerns to the Bureau Environmental Epidemiology.

DOCUMENTATION:

1. Housing Quality Standards Inspection Form
2. Lead-Based Paint Disclosure Form, if applicable
3. Lead-based paint educational materials
4. HUD Lead-Based Paint Visual Assessment Training Certificate
5. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

SUMMARY:

The Violence Against Women Act (VAWA) provides protections and remedies for program applicants and beneficiaries who are survivors of domestic violence, dating violence, sexual assault, or stalking. Despite the name of this law, VAWA protection and remedies are available regardless of sex, gender identity, or sexual orientation. Per 24 CFR §5, Subpart L, VAWA applies to all HUD programs, including HOPWA.

POLICY:

1. Clients who apply for TBRA assistance through the RW Part B Program may not be denied admission to, denied assistance under, terminated from participation in, or evicted from the property on the basis or as a direct result of the fact that the client is or has been a survivor of domestic violence, dating violence, sexual assault, or stalking if the client otherwise qualifies for admission, assistance, participation, or occupancy. (Fair Housing Act)
2. Clients and landlords must be provided with appropriate VAWA related forms, including the VAWA lease addendum; Certification of Domestic Violence, Dating Violence, or Stalking form; and the VAWA Notice of Occupancy Rights. (Appendix A13, A14, and A15)
3. All RW Part B Program TBRA assisted properties must have a signed VAWA lease addendum to meet VAWA requirements. The lease addendum must be signed by the client and the landlord. (Appendix A13)
4. The client must complete the Certification of Domestic Violence, Dating Violence, or Stalking form if the landlord requests certification that the client is a victim of domestic violence, if applicable. (Appendix A14)
5. Case Managers must fill out the appropriate regional information on the VAWA Notice of Occupancy Rights to ensure clients who may be experiencing domestic violence are informed of resources in their area of residence.
6. The client may refer to the VAWA Notice of Occupancy Rights if the client is being evicted due to domestic violence. (Appendix A15)

PROCEDURE:

1. Case Managers must provide clients and landlords with appropriate blank VAWA related forms to be completed, if applicable.
2. Case Managers must verify that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.

DOCUMENTATION:

1. VAWA lease addendum
2. Certification of Domestic Violence, Dating Violence, Sexual Assault, or Stalking and Alternative Documentation form, if applicable
3. VAWA Notice of Occupancy Rights form, if applicable

SUMMARY:

Clients who request access to TBRA assistance may be placed on an RW Part B Program housing assistance waitlist if funding becomes restricted.

POLICY:

1. The RW Part B Program will establish a waitlist if TBRA assistance becomes unavailable to eligible clients due to budgetary issues, etc.
2. The DHSS HIV Support Services Program Coordinator will notify all regional supervisors, QSMs, and the DHSS Benefits Administrator if a waitlist becomes necessary.
3. The DHSS HIV Support Services Coordinator will update the TBRA waitlist every three months, as needed.
4. Clients must meet all requirements for TBRA assistance in order to be placed on the waitlist.
5. Clients may receive up to three months of STRMU assistance while on the TBRA waitlist. (Subsection 7.4)
6. Client's position on the waitlist may be determined by the score calculated in Section C-Long-Term Housing Assessment of the Housing Utility Assistance Calculation Worksheet. (Appendix A3)
7. Clients with no income must have a signed Income Attestation Form. (HIV Case Management Manual Section 3.2.3)
8. Clients must apply for all community housing assistance programs and keep their application(s) current.
9. Clients that let their community housing application(s) expire will be removed from the TBRA waitlist.
10. The Case Manager must use the Public Housing Verification Worksheet in the event that the client is not able to obtain written verification of application or eligibility for other housing or utility assistance programs. (Appendix A11)

PROCEDURE:

1. The DHSS HIV Support Services Coordinator will create a TBRA waitlist, if necessary.
2. The DHSS HIV Support Services Coordinator will notify all regional supervisors, QSMs, and the DHSS Benefits Administrator if a waitlist becomes necessary.
3. Case Managers must ensure that clients are eligible for the TBRA assistance prior to requesting a client be added to the TBRA waitlist.
4. Case Managers must verify that all required documentation is correct and complete prior to uploading into the "Documents" module in the electronic client database.
5. Case Managers must send a communicate to the DHSS HIV Support Services Coordinator if changes are made to Section C-Long-Term Housing Assessment of the Housing Utility Assistance Calculation Worksheet.
6. Case Managers must use the most current forms located in the electronic client database.

DOCUMENTATION:

1. Housing/Utility Assistance Calculation Worksheet
2. Proof of application(s) to community-based housing assistance programs
3. Public Housing Verification Worksheet, if applicable
4. Income Attestation Form, if applicable
5. Current lease
6. Other documentation, as requested by DHSS or the DHSS Benefits Administrator

Appendix A1

Budget Plan Worksheet and Instructions

Budget Plan Worksheet

Client Name:			
Date:		**DCN:**	

	Resources	Month	Month	Month	Comments
1	Gross Client/Family Income				
2	Rent/Utility Assistance (include LIHEAP, local community resources, **HOPWA**, Section 8, etc.)				
3	Food Stamps				
4	Other regular support from an absent family member or someone not living in the housing unit				
5	Other assistance (use comments to explain)				
6	**Total Resources**				

List actual expenses being paid each month in the appropriate categories.

	Expenses	Month	Month	Month	Comments
7	Rent				
8	Mortgage				
9	Utilities (heat, electric, water, sewer)				
10	Food				
11	Cell Phone				
12	Home Telephone				
13	Trash Service				
14	Child Care				
15	Gasoline				
16	Transportation				
17	Automobile Payment				
18	Automobile Insurance				
19	Medical Co-Pays/Expenses				
20	Health Insurance				
21	Cable/Satellite TV				
22	Internet				
23	Loans/Debt (what type)				
24	Payroll Deductions				
25	Payroll Deductions				
26	Other (Use comments to explain in more than one word)				
27	Other (Use comments to explain in more than one word)				
28	Other (Use comments to explain in more than one word)				
29	**Total Expenses** (line 7 thru 28)				
30	**Total Income/Resources** (line 6)				
31	**Balance** (line 30 – line 29)				

Client Name:	Enter the client's legal first and last name.
Date:	Enter the date that the form is being completed.
DCN:	Enter the client's eight-digit DCN number.
Resources Insert each amount into the first available column labeled "Month."	
1. Gross Client/Family Income	Enter the total monthly amount of gross income that the client and all gross income for their spouse and dependents, if applicable.
2. Rent/Utility Assistance (include LIHEAP, local community resources, HOPWA, Section 8, etc.)	Enter the total amount of assistance that the client receives per month for rent and utilities. Only include the amount of assistance that a client **currently** receives and note the program name in this column (e.g. HOPWA, Section 8, etc.). If the client is **not currently** receiving assistance from a program, insert $0.
3. Food Stamps	Enter the total amount of food stamps that the client receives per month.
4. Other regular support from an absent family member or someone not living in the housing unit	Enter the total amount of other financial support the client receives per month from other family members/individuals who do not reside in the home.
5. Other assistance (use comments to explain)	Enter the total amount of any other financial assistance the client may receive per month that does not fall into the above-itemized resources.
6. Total Resources	This field automatically adds 1 to 5 in the fillable PDF. **Note:** If you are not using the fillable PDF, you must total rows 1 to 5.
Expenses Insert each mount into the first available column labeled "Month"	
7. Rent	Enter the total amount of rent per month that the client is responsible for. Insert a comment if the client has a roommate(s) to document the cost difference between the Housing/Utility Calculation Worksheet and the lease.
8. Mortgage	Enter the total amount of the client's mortgage per month.
9. Utilities (heat, electric, water, sewer)	Enter the total estimated amount for utilities per month that the client is responsible for. Insert a comment if the client has a roommate(s) to document that the client is only responsible for a portion of utility costs.
10. Food	Enter the estimated amount of food costs for the client, their spouse, and their dependent(s) per month. This amount may be different than the amount of food stamps the client receives, if any.
11. Cell Phone	Enter the total monthly cost for the client's cell phone bill.
12. Home Telephone	Enter the total monthly cost for the client's home telephone bill.
13. Trash Service	Enter the total monthly cost for trash services. If the trash service is billed quarterly, divide the quarterly amount by three to get a monthly amount.
14. Child Care	Enter the client's total monthly cost of unreimbursed child care expenses. Do not include expenses that are reimbursed or are paid by another payer source.

15. Gasoline	Enter the client's total monthly cost for gasoline.
16. Transportation	Enter the client's total unreimbursed transportation costs, such as expenses for bus passes, taxis, etc. Do not include reimbursed transportation costs or expenses paid for by another payer source.
17. Automobile Payment	Enter the total monthly automobile payment for the client's personal automobile.
18. Automobile Insurance	Enter the total monthly insurance for the client's automobile.
19. Medical Co-Pays/Expenses	Enter the total amount of unreimbursed monthly medical co-pays or other medical expenses. Do not include expenses that are reimbursed to the client or paid for by another payer source.
20. Health Insurance	Enter the total health insurance premium cost per month for the client. Do not include premiums paid for by other payer sources.
21. Cable/Satellite TV	Enter the client's total monthly cable and/or satellite cost.
22. Internet	Enter the client's total monthly internet cost.
23. Loans/Debt (what type)	Enter the total monthly amount the client pays towards a loan or debt not listed above. If an amount is inserted in this column, a note must be put in the "Comments" column to explain what the loan or debt is.
24. Payroll Deductions **25. Payroll Deductions**	Enter any monthly payroll deductions such as restitution payments or child support but excluding employer insurances and taxes from wages. If the client has more than one payroll deduction, insert each amount on a separate line. A note must be put in the "Comments" column to explain what the payroll deduction is for.
26. Other (Use comments to explain in more than one word) **27. Other (Use comments to explain in more than one word)** **28. Other (Use comments to explain in more than one word)**	Enter the total of any other unreimbursed monthly expense the client has that is not itemized above. A note must be put in the "Comments" column to explain what the expense is. Each expense amount should be listed on a separate line with a separate note in the "Comments" column.
29. Total Expenses (line 7 thru 28)	This field automatically adds rows 7 – 28 in the fillable PDF. **Note:** If you are not using the fillable PDF, you must add the total of rows 7-28 and insert the total in this field.
30. Total Income/Resources (line 6)	This field automatically adds rows 1-5 in the fillable PDF. **Note:** If you are not using the fillable PDF, you must insert the amount from row 6 (the total of rows 1-5) in this field.
31. Balance (line 30 – line 29)	This field automatically subtracts the total of row 29 from the total of row 30 if you are using the fillable PDF. **Note:** If you are not using the fillable PDF, you must subtract row 30 from row 29 in this field. If the amount is negative, a minus sign must be inserted in front of the amount.

Appendix A2

Transportation Request Form and Instructions

Transportation Request Form

Type of Request (Check One):	☐ Medical Transportation	☐ Consumer Group
Does the Client Have Medicaid? ☐ Yes ☐ No	Travel Month:	County:
If yes, why was Medicaid Transportation not utilized?		DCN:
Client Name:	Agency:	
Case Manager:	Total Gas Card Value:	
Case Manager's Phone Number:	Gas Card Type: ☐ QT ☐ Casey's ☐ Conoco ☐ BP	

Travel Date	Name of Provider	Complete Address & Phone Number	No. of Miles	Rate $0.43/mile	Total
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				$0.43	
				Total:	

Clients receiving Medicaid benefits are required to use Medicaid Transportation to access Medicaid funded services.

I understand that my Case Manager and/or HSI will verify appointments listed on this form for accuracy. Fraudulent information may result in the termination of transportation services. Transportation services are intended to reimburse a client for medical transportation expenses for the treatment of his/her primary medical diagnosis. Request must be completed in full and should be forwarded to HSI by your Case Manager **no later than the 15th of the month following the dates of travel.** Please list only trips occurring during the same calendar month on a single request form. Incomplete requests will be returned to your Case Manager and will result in delayed reimbursement.

Client Signature:	Date:
Case Manager Signature:	Date:

Your signature above indicates that you have verified the above information to be true and accurate.

Revised May 2021

Type of Request (Check One):	Check the box next to the appropriate type(s) of travel the client is requesting assistance with.
Does the client have Medicaid?	Check the box next to the appropriate answer for the client.
Travel Month:	Select the travel month from the drop-down menu. **Note:** If you are not using the fillable PDF, you must insert the month that the travel reimbursement request is for.
County:	Select the appropriate county from the drop-down menu that the client resides in. **Note:** If you are not using the fillable PDF, you must insert the county that the client resides in.
Client Name:	Enter the client's legal first and last name.
Agency:	Enter the name of the case management agency.
Case Manager:	Enter the first and last name of the client's case manager.
Total Gas Card Value:	This field automatically inserts the total of mileage reimbursement amounts inserted below. **Note:** If you are not using the fillable PDF, you must insert the total of all rows with mileage reimbursement amounts from the table below.
Case Manager's Phone Number	Enter the case manager's 10 digit phone number.
Gas Card Type:	Check the box next to the name of the gas station that the client wants to receive their reimbursement gift card to.
Travel Date (all rows)	Enter the date of travel in the first available row. Each separate date must be inserted on a separate row. (Only one date per row).
Name of Provider (all rows)	Enter the name of the provider(s) that the client traveled to for the date of travel.
Complete Address & Phone Number (all rows)	Enter the complete address and phone number for the provider that the client traveled to for the date of travel.
No. of Miles (all rows)	Enter the round-trip number of miles that the client traveled on the date of travel. Only one round-trip will be reimbursed per day. Round-trip includes travel from home to the provider and return to the client's home.
Rate $0.43/mile (all rows)	The amount entered in this column is the amount per mile that the client will be reimbursed.
Total (all rows)	This field automatically multiples the number of round-trip miles by $0.43. **Note:** If you are not using the fillable PDF, you insert the total of the "No of Miles" field by $0.43.
Total:	This field automatically adds all of the totals of mileage reimbursement from the entries above. **Note:** If you are not using the fillable PDF, you must add the amount of reimbursement totals from above and insert the amount in this field.
Client Signature:	The client must sign on this line.
Date:	Enter the date that the client signed the completed form.
Case Manager Signature:	The Case Manager must sign on this line.
Date:	Enter the date that the Case Manager signed the completed form.

Appendix A3

Housing/Utility Calculation Worksheet and Instructions

Housing/Utility Calculation Worksheet

Section A – Client Data		
Client Name:	DCN:	Date:

Section B - Calculation								
1.	Enter the annual gross income for the family (before any deductions)							$
2.	Enter the number of eligible clients in the housing unit							
3.	Line 1 divided by 12 months							$
4.	Line 3 multiplied by 10% equals	$						
5.	Enter the amount of monthly unreimbursed medical expenses						$	
6.	Enter the amount of monthly unreimbursed childcare expenses						$	
7.	Is one elderly/disabled person in the housing unit?		(1 max)	$33.00	$			
8.	Enter the number of dependent(s) in the home		multiply by	$40.00	$			
9.	Total of lines 5, 6, 7, and 8							$
10.	Line 9 subtracted from Line 3							$
11.	Line 10 multiplied by 30%	$						
12.	Actual rent/mortgage	$	plus utility cost	$	For a total of	$		
13.	Enter number of allowable bedrooms in the housing unit		$	Fair Market Rent	$			
14.	The lesser of Line 12 or Line 13							$
15.	Enter the actual number of families or independent adults living within the housing unit							
16.	Line 14 divided by Line 15							$
17.	The greater of Line 4 or Line 11							$
18.	Line 17 subtracted from Line 16. This is the amount of assistance the client is eligible for.							$

Section C – Tenant Based Rental Assistance (TBRA) Assessment

Fill out **only for clients who are requesting TBRA Housing** assistance who are **at or below 125% of FPL**.

To determine priority and placement for TBRA assistance, please score one point for each of the following areas, if applicable to the client.

	Client has no resources to pay for housing and is currently in eviction status
	Client's income is verified as zero
	Client has income but is at or below 80% of the FPL
	Client is not eligible for public housing
	Client is homeless or does not have a permanent address
	Client has been hospitalized in the past 6 months related to their HIV diagnosis
	Client was released from a treatment facility and/or incarceration in the past 6 months
	Client has a current documented diagnosis other than HIV that affects their ability to maintain housing
	Client has dependent(s) in the home – **Add one point for each dependent**
	Total Points

Section A – Client Data	
Client Name:	Enter the client's legal first and last name.
DCN:	Enter the client's 8 digit DCN number.
Date:	Enter the date that the form is being completed on.
Section B - Calculation	
Line 1:	Enter the annual income amount for the client and any/all family members as it is documented in the electronic client database.
Line 2:	Enter the number of eligible clients in the household (include the client and other HIV positive individuals enrolled in HIV Case Management)
Line 3:	Automatically divides line 1 by 12 months. **Note:** If you are not using the fillable PDF, you must divide the client's annual income amount (line 1) by 12 and insert the monthly amount in this field.
Line 4:	Automatically multiplies line 3 by 10%. **Note:** If you are not using the fillable PDF, you must insert the client's monthly income amount (line 3) multiplied by 0.1.
Line 5:	Enter the amount of unreimbursed medical expenses incurred by the client on a monthly basis. This amount should only include out-of-pocket expenses for co-pays, deductibles, health insurance premiums (insurance, Medicare, etc.), over-the-counter medications, medical supplies, etc. that occur on a regular basis and are **not** reimbursed by another payer source.
Line 6:	Enter the amount of unreimbursed childcare expenses incurred by the client on a monthly basis for only the children residing in the home. These expenses include anticipated costs for children 12 years of age and younger that enable the client to work, seek employment, or further their education and are **not** reimbursed by another payer source.
Line 7:	Enter "1" if anyone in the client's household who is at least 62 years of age or has been determined to be disabled by the Social Security Administration (SSA) or MO HealthNet. Only one deduction per household per year is allowed (maximum of $400 per year).
Line 8:	Enter "1" for each qualifying dependent in the housing unit. Dependents include household members that are under the age of 18, are disabled as determined by SSA or MO HealthNet), or are a full-time student under 25 years of age. Dependents **do not** include the client or their spouse. Dependents must meet the following criteria: 1. Relationship: the child, stepchild, adopted child, foster child, brother, sister, or a descendant of one of these (for example, a grandchild, or nephew). 2. Residence: the person must live in the home for a minimum of six months and one day each calendar year. 3. Age: must be under 19 years old at the end of the calendar year; or under 25 years old and full-time student for at least five months of the year; or any age

	and determined to be permanent and totally disabled by SSA or MO HealthNet. 4. Support: the individual did not provide more than half of their own support during the calendar year.
Line 9:	Automatically adds line 5, 6, 7, and 8. **Note:** If you are not using the fillable PDF, you must insert the added total of rows 5, 6, 7, and 8 in this field.
Line 10:	Automatically subtracts line 9 from line 3. **Note:** If you are not using the fillable PDF, you must subtract the total of line 9 from the total of line 3 and insert the amount in this field.
Line 11:	Automatically multiplies line 10 by 30%. **Note:** If you are not using the fillable PDF, you must take multiply the total of line 10 by 0.3 and insert the amount in this field.
Line 12:	**Actual Rent/Mortgage:** Enter the total amount of monthly rent or mortgage for the property. Pet expenses are not allowed. Do not include pet expenses in this amount.
	plus utility cost: Enter the monthly allowance for utilities from the Rent Reasonableness Checklist located in the electronic client database. If utilities are included in the monthly rent amount, insert $0 as they are not an eligible expense. Pet expenses are not allowed. Do not include pet expenses in this amount.
	For a total of: Automatically adds *Actual Rent/Mortgage* and *plus utility cost*. **Note:** If you are not using the fillable PDF, you must insert the total of *Actual Rent/Mortgage* and *plus utility cost* in this field.
Line 13:	**Enter number of allowable bedrooms in housing unit:** Enter total number of allowable bedrooms in the housing unit. The allowable bedroom number is determined based on the number of people living in the home regardless of relationship to the client. The allowable number of bedrooms is based on the lesser of the actual number of bedrooms in the home or the number of allowable bedrooms as determined by the number of persons living in the housing unit. The number of allowable bedrooms is limited by the number of persons living within the same housing unit. Example 1: Client + two roommates = 3 bedrooms. Example 2: Client + Spouse + one dependent + one roommate = 3 bedrooms (client and spouse share a bedroom, with the dependent and roommate having separate rooms).
	Fair Market Rent: Enter the current Fair Market Rent (FMR) amount for the number of allowable bedrooms determined above. FMR standards are located in the electronic client database here: Support > MO DHSS > MO Case Management Forms > Outstate Forms
Line 14:	Automatically fills in the lesser of line 12 or 13. **Note:** If you are not using the fillable PDF, you must insert the lower number from line 12 or 13.
Line 15:	Enter the number of separate families and/or independent adults living in the home.
Line 16:	Automatically divides line 14 by line 15. **Note:** If you are not using the fillable PDF, you must divide the amount in line 14 by the number of separate families from line 15, then insert the amount in line 16.
Line 17:	Automatically fills in the greater of line 4 or line 11. **Note:** If you are not using the fillable PDF, you must insert the larger amount from line 4 or line 11 in this field.

Line 18:	This line automatically calculates the amount of monthly housing/utility assistance the client is eligible for by subtracting the amount in line 17 from line 16. **Note:** If you are not using the fillable PDF, you must subtract line 17 from line 16 and insert that amount in this field.
Section C – Long Term Housing Assessment	
Section C **must** be filled out for all clients who are requesting Tenant Based Rental Assistance (TBRA) **and** have an income level **at or below 125% of the Federal Poverty Level (FPL).**	
Documentation to verify each point earned below must be uploaded and/or documented in the electronic client database.	
Client has no resources to pay for housing and is currently in eviction status	Enter "1" if the Case Manager has written or verbal verification from the landlord that the client is being evicted.
Client's income is verified as zero	Enter "1" if client has no income. Verification may include, but is not limited to, Medicaid verification, separation letter from previous employer, unemployment denial, etc.
Client has income but is at or below 80% of the FPL	Enter "1" if the client has provided proof of income but has an income at or below 80% of the FPL.
Client is not eligible for public housing	Enter "1" if the Case Manager has written or verbal verification that the client does not qualify for public housing.
Client is homeless or does not have a permanent address	Enter "1" if the Case Manager has witnessed or verification that the client is couch surfing, living in a shelter, etc.
Client has been hospitalized in the past 6 months related to their HIV diagnosis	Enter "1" if the client has been hospitalized in the past 6 months.
Client was released from a treatment facility and/or incarceration in the past 6 months	Enter "1" if the client has been released from a substance abuse treatment facility, mental health treatment facility, or incarceration within the past 6 months.
Client has a current documented diagnosis <u>other than HIV</u> that affects their ability to maintain housing	Enter "1" if the client has a diagnosis for a non-HIV related health condition that affects their ability to maintain housing. This diagnosis must be documented in the client's 2.0MCMAT.
Client has dependent(s) in the home – Add one point for each dependent	Enter the number of dependents that the client(s) has living in the housing unit. There should be one point per person.
Total Points	This field automatically adds the number inserted in all rows of Section C. **Note:** If you are not using the fillable PDF, you must add the number of points the client has in Section C.

Appendix A4

Lease Standards Checklist

Lease Standards Checklist

Leases must meet the following standards for clients to be eligible to receive housing assistance. If any response is NO, the lease will not meet housing requirements and assistance with rent will be denied. Leases must be completed, readable and signatures must be legible.

NOTE: Pet expenses can be included in the lease but cannot be paid for by the program. Costs for internet, cable, and additional expenses for amenities will be deducted from the rent cost.

Client Name:	**DCN:**	**Date :**	
Criteria		**Yes**	**No**
1. Lease is typed.			
2. Lease is current.			
3. Identifies landlord's name and address.			
4. Identifies all occupants, by legal name, living in the unit.			
5. Lease is signed by tenant and landlord.			
6. States monthly rent amount.			
7. States deposit amount.			
8. Lease does not contain "first and last month's rent."			
9. Lease identifies who is responsible for utilities.			
10. Lease identifies costs of included amenities, cable, or internet (if applicable)			
11. Lease identifies landlord's responsibility for maintenance and services of unit.			
12. Lease identifies conditions necessary for eviction.			
13. Lease prohibits discrimination.			
14. Lease does not contain language that states the tenant agrees to be sued, admit guilt or to a judgement in favor of the landlord brought in connection with the lease.			
15. Lease does not contain language that states the landlord/owner may take, hold, or sell personal property of the household members without notice to the tenant and a court decision.			
16. Lease does not contain language that states the tenant agrees to not hold the landlord/owner, or their agents, responsible for any action or failure to act.			
17. Lease does not contain language that states the owner may institute a lawsuit without notifying the tenant.			
18. Lease does not contain language that states the landlord/owner may evict the tenant or household members without instituting a civil court proceeding.			
19. Lease does not contain language that states the tenant agrees to pay the attorney's fees and/or other legal costs even if the tenant wins in a court proceeding. The tenant may be obligated to pay attorney's fees and/or other legal costs if the tenant loses in a court proceeding.			
20. Lease does not contain language that states the tenant agrees to pay additional rent or fees to the landlord out of pocket once occupancy takes place.			

Appendix A5

Housing Assistance Verification (HAV) Form and Instructions

Healthcare Strategic Initiatives

HOUSING ASSISTANCE VERIFICATION (HAV) FORM

This form must be completed upon request for assistance unless the HAV has been completed within the past year or with any changes.

TENANT INFORMATION

Tenant Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

****
****

REMAINDER OF INFORMATION TO BE COMPLETED BY LANDLORD ONLY

Lease Term: _____ to _____
(Please include Start Date, even if Lease is Month to Month)

When the lease expires does it:
- ☐ go month to month?
- ☐ automatically renew?
- ☐ annual signing?

Number of Bedrooms: _____ Number of tenants in residence: _____

Amount of Deposit: _____ Amount of Rent: _____

Does rent include payment for the following? ☐ Gas ☐ Electric ☐ Water ☐ Sewer ☐ Trash
(Check all that apply)

LANDLORD INFORMATION

Please check the appropriate box below:

☐ The lessee is a member of my family related by birth, marriage, or adoption.

☐ The lessee is **not** a member of my family related by birth, marriage, or adoption.

Owner Name: _____ Phone Number: _____

Owner Address: _____
Street Address

_____
City State Zip

Check Payable to: _____ Phone Number: _____
(If different from owner) Fax Number: _____
Email: _____

Mail Rent Check to: _____
(If different from owner address) Street Address

_____
City State Zip

Healthcare Strategic Initiatives

HOUSING ASSISTANCE VERIFICATION (HAV) FORM

This form must be completed upon request for assistance unless the HAV has been completed within the past year or with any changes.

I hereby agree to rent the aforementioned property to this tenant for the amount stated above. I understand that any housing/utility assistance provided is transitional in nature and not to provide long term assistance. I also agree to accept payment from the third-party payer on a month-to-month basis to either pay in full or assist with this monthly rental payment. There is no contractual obligation on either the part of the third-party payer (HSI) or landlord and I understand that this does not in any way obligate landlord or HSI any lease/tenant agreement. I understand that HSI is legally required to obtain a completed and signed Form W-9 from the owner of the property every year that payment is made by HSI. I understand that no rental checks will be released without a completed W-9.

I also understand this assistance is based on calculation of the client's income and Fair Market Rent (FMR) for this county. Any change in said income or FMR rate may affect the portion for which the client(s) is responsible. If there is a change in the eligible amount of assistance, you will receive a Housing Assistance Notification letter stating the amount of rent to be paid by the rent as well as HSI. This assistance program is dependent on the client's full participation and agreement to follow all policies, and if not followed, the program assistance could end without notice.

Property Owner/Rent Recipient Signature: _____

Date: _____

The HAV is used to verify tenant and landlord information. This form must be completed upon request for assistance unless the HAV has been completed within the past year or with any changes.

1. Case manager or Tenant should complete the "Tenant" section of the form including:
    a. Tenant Name- Name should be listed as the resident's (client's) legal name and must be consistent with the name entered in the Client Profile in the electronic client-level database.
    b. Tenant Address-Address on the Housing Assistance Verification form must match the address listed on the lease **and** in the Housing module in the electronic client-level database.
2. The Housing Assistance Verification form (HAV) should be completed upon the agreement of the signed lease/tenant contract. The information presented in this section must be able to be verified in the lease.
3. Landlord should complete the "Landlord Only" section of the form including:
    a. Lease Term Start and End Date
    b. Lease Renewal Option
    c. Deposit and Rent Amount
    d. Utilities included or not included in Rent Amount
    e. The number of bedrooms should include what is verifiable as being a bedroom.
    f. The number of tenants in the residence must be verifiable by the listed number of "Tenants" listed within the lease. The number of tenants in the residence should be consistent with the number of household members being claimed in the Social Supports module of the electronic client database.
4. The Landlord is responsible for completing the following sections of the form; information must be clear and legible for processing of financial assistance.
    a. Family Member- One box must be check marked identifying if the Tenant and Landlord is family or not.
    b. Owner Name and Phone Number- If the Owner/Landlord name and the Check Payable to information is the same, only completing the owner section of this form is acceptable. Phone number should be current and valid.

c. Owner Address- The complete address is important for mailing purposes, i.e., Apartment Letter and/or Number or if adding an "Attn:" line item.

d. Check Payable to- If the Owner/ Landlord name and the Check Payable to information is different.

e. Fax Number and/or Email- The program provides Automated Clearing House Direct Deposit for "Tenants/Clients" that are eligible for Long Term HOPWA Housing Assistance. The fax and/or email will be used solely as the first point of contact between Owner/Landlord and the DHSS Benefits Administrator for confirmation of program eligibility and introducing ACH Direct Deposit for assistance directly to the Owner/Landlord banking account.

5. Owner/Landlord Signature and Date- Signature and date are required from Property Owner and/or Rent Recipient i.e., Property Manager, Leasing Agent, Regional Manager, etc. for this document to be acceptable

6. **If the Landlord Address changes, please notify DHSS Benefits Administrator by changing the HSI- Housing Srvs/HOPWA/Rental Subsidy or HSI- Housing Srvs/RW/Rental Subsidy service referral to 2SRR and inserting a note regarding the Landlord Address change in information.**

Appendix A6

Housing Assistance Notification (HAN) Form and Instructions

Healthcare Strategic Initiatives

Housing Assistance Notification (HAN) □ Initial □ Change

This form must be completed upon request for assistance unless the HAN has been completed within the past year, or with any changes.

Effective Date ____/____/_____

TENANT INFORMATION

Tenant Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Total Amount of **Monthly** rent due per lease $_____

Eligible Amount of rent **to be paid by HSI** to the landlord $_____

Client responsibility- Balance due of rent to be paid $_____
(Monthly rent minus amount to be paid by HSI)

HOUSING ASSISTANCE VERIFICATION FORM

I hereby agree to rent the aforementioned property to this tenant for the amount stated above. I understand that any housing/utility assistance provided is transitional in nature and not to provide long term assistance. I also agree to accept payment from the third-party payer on a **month-to-month** basis to either **pay in full or assist with this monthly rental payment**. There is **no contractual obligation on either the part of the third-party payer (HSI) or the landlord** and I understand that this does not in any way obligate the landlord or HSI to any lease/tenant agreement. I understand that HSI is legally required to obtain a completed and signed Form W-9 (attached) from me every year I receive payment from HSI. I understand that no rental checks will be released without a completed W-9.

I also understand this assistance is based on a calculation of the client's income and Fair Market Rent for this county. Any change in said income or FMR rate may affect the portion for which the client(s) is responsible. If there is a change in the eligible amount of assistance, you will receive a Housing Assistance Notification letter stating the amount of rent to be paid by the renter as well as HSI. This assistance program is dependent on the client(s) full participation in the program and agreement to follow all policies and if not followed, the program assistance could end without notice.

Date provided to landlord_____ Method provided by: ☐ email ☐ fax ☐ mail ☐ in person

Date provided to client_____ Method provided by: ☐ email ☐ fax ☐ mail ☐ in person

The HAN is used to determine the amount of eligible financial assistance provided by the Program and the client's financial responsibility. This form must be completed upon request for assistance by the case manager unless the Housing Assistance Notification HAN has been completed within the past year or with any changes.

1. The HAN form should be filled out upon the initial request for assistance in conjunction with the Missouri DHSS Housing/Utility Assistance Calculation Worksheet. Responsibility is based on the eligible amount of assistance determined on line #18 of the Housing/Utility Assistance Calculation Worksheet, which calculates financial eligibility of the Housing Assistance Program and "Tenant/Client" financial accountability.
    a. Initial or Change Box- Mark whether this form is for the determination of the initial eligible amount of assistance or if there has been a change in the amount of eligible financial assistance.
    b. Date- Enter the Effective Date for verification of when the initial or change in financial assistance should commence.
2. Case manager should complete the "Tenant" section of the form including:
    a. Tenant Name- Name should be listed as the resident's (client's) legal name and must be consistent with the name entered in the Client Profile in the electronic client-level database.
    b. Tenant Address-Address on the Housing Assistance Notification form must match the address listed on the lease **and** in the Housing module in the electronic client-level database.
    c. Amount of Rent- Total Amount of **Monthly** rent must be uniform with the lease. The Eligible Amount of rent **to be paid by HSI** must be uniform with DHSS Housing-Utility Calculation worksheet. The **Client Responsibility** is the Total Amount of **Monthly** rent minus the Eligible Amount of rent **to be paid by HSI.**
3. The "Date" and "Method" that the Housing Assistance Notification document is provided to landlord and the client:
    a. Date and Method Confirmation-The Case Manager must enter the date and method in which the document was provided to **both** the client and the landlord for this document to be acceptable.

Appendix A7

Housing Quality Standards Inspection Form

Housing Quality Standards Inspection Form

Client Name:			DCN:		
Address:			Phone:		
City:		State:		Zip Code:	

Properties must be safe, sanitary, and in compliance with the quality standards below. Mark each statement **A** for approved or **D** for deficient. Include comments if any standards are deemed deficient. Properties must meet all standards in order for assistance to be approved.

Standard	A	D	Comments
Meets all applicable local codes: Must not be deemed unsafe or unsanitary by local housing codes.			
Illegal Activity Observed: All housing must be free of all illegal activity (e.g. manufacture or sale of illegal substances, child/elderly abuse, prostitution, etc.)			
Structure and Materials: Structures must be sound and does not pose a threat to the health or safety of the occupants.			
Access: Accessible and capable of being utilized without unauthorized use of other private properties and provides means to escape in case of fire.			
Space and Security: Each occupant must have adequate space and security for themselves and their belongings, including a place to sleep.			
Interior Air Quality: All rooms must have natural or mechanical ventilation and is free of pollutants in the air that may threaten the health of occupants.			
Water Supply: Water must be free of contaminants at levels that threaten the health of occupants.			
Thermal Environment: Housing must have adequate heating and/or cooling that is in proper operating condition.			
Lighting and Electricity: Must have adequate natural or artificial lighting for indoor activities and that supports the health and safety for residents. Must have sufficient electrical sources for essential appliances.			
Food Preparation and Trash Disposal: Housing must have an area that is suitable for safe food preparation and necessary appliances to store, prepare, and serve food in a sanitary manner. Must have appropriate trash removal or disposal accommodations.			
Sanitary Condition: Housing and any appliances must be in sanitary condition.			
Smoke Detectors: Must have installed single or multi-station smoke detectors outside of each sleeping area, on each level, and are clearly audible and/or have accommodations for sensory impairments of occupants. Smoke Detectors must be installed according to NFPA 74 or more stringent local policies if applicable.			
Lead-Based Paint: Was the home built before 1978? ☐ Yes ☐ No If yes, does the housing unit have any defective paint surfaces such as cracking, scaling, chipping, peeling, or loose paint? If no, check the box for approved.			
Has documentation been provided that proves all lead-based paint has been abated in accordance with 24 CFR Part 35?			☐ Yes ☐ No ☐ N/A
Will a child under six years old or a pregnant woman be residing in the home? ☐ Yes ☐ No	Date that lead-based paint educational materials were provided to the client:		

Short-Term Rental, Mortgage, and Utility Assistance Requests (STRMU):	
	Client is requesting STRMU assistance and has attested that their home meets all inspection standards listed above.

Initial and Date

Although I am not a qualified building inspector, I have visually observed the housing unit and have noted the above results.

Case Manager Signature _____ Date: _____

Client Signature _____ Date: _____

Revised May 2021

Appendix A8

Lead-Based Paint Disclosure Form

Lead-Based Paint Disclosure Form

Lead Warning Statement

Housing built before 1978 may contain lead-based paint. Lead from paint, paint chips, and dust can cause health hazards if not managed properly. Lead exposure can be harmful, especially to young children and pregnant women. Before renting pre-1978 housing, landlords must disclose the presence of known lead-based paint and/or lead-based paint hazards in the dwelling. Lessees must also receive a federally approved pamphlet on lead poisoning prevention

Lessor's Disclosure

1. Presence of lead-based paint and/or lead-based paint hazards (check a. or b. below):
   a. _____ Lessor knows that lead-based paint and/or lead-based paint hazards are present in the housing unit. Please explain:

   _____

   _____

   b. _____ Lessor has no knowledge of lead-based paint and/or lead-based paint hazards in the housing unit.
2. Records and reports available to the lessor (check a. or b. below):
   a. _____ Lessor has provided the lessee with all available records and reports pertaining to lead-based paint and/or lead-based paint hazards in the housing unit (list documents below).

   _____

   _____

   b. _____ Lessor has no reports or records pertaining to lead-based paint and/or lead-based paint hazards in the housing unit.

Lessee's Acknowledgement (initial)

1. _____ Lessee has received copies of all information listed above.
2. _____ Lessee has received the pamphlet *Protect Your Family from Lead in Your Home.*

Agent's Acknowledgement (initial)

1. _____ Agent has informed the lessor of the lessor's obligation under 42 U.S.C. 4852(d) and is aware of his/her responsibility to ensure compliance

Certification of Accuracy

The following parties have reviewed the information above and certify, to the best of their knowledge, that the information they have provided is true and accurate.

Lessor's Signature	Date	Lessor's Signature	Date
Lessee's Signature	Date	Lessee's Signature	Date
Agent's Signature	Date	Agent's Signature	Date

Revised May 2021

Appendix A9

Lead-Based Paint Educational Materials

Educational Information

Protect Your Family from Lead in Your Home – Real Estate Disclosure:
https://www.epa.gov/lead/protect-your-family-lead-your-home-real-estate-disclosure

MO DHSS Lead Poisoning Website: https://health.mo.gov/living/environment/lead/index.php

MO DHSS Lead Poisoning Health Effects: https://health.mo.gov/living/environment/lead/health-effects.php

MO DHSS What is Lead? https://health.mo.gov/living/environment/lead/sources.php

MO DHSS Prevention and Treatment: https://health.mo.gov/living/environment/lead/prevent-treat.php

MO DHSS Lead-Based Paint Publications:
https://health.mo.gov/living/environment/lead/publications.php

Federal Lead-Based Paint Information

Lead-Based Paint Disclosure Rule:
https://www.hud.gov/program_offices/healthy_homes/enforcement/disclosure

Lead-Based Paint Exemptions:
https://www.law.cornell.edu/cfr/text/24/35.115

Lead-Based Paint and Tenant-Based Rental Assistance Programs:
https://www.law.cornell.edu/cfr/text/24/part-35/subpart-M

Missouri Lead-Based Paint Laws and Regulations

MO DHSS Lead-Based Paint Laws: https://health.mo.gov/living/environment/lead/laws-regs-mans.php

NOTE: All links are current as of May 2021.

Appendix A10

Rent Reasonableness Checklist

Rent Reasonableness Checklist

The rent charged for a property must be considered reasonable in relation to rent that is currently being charged for comparable properties in the private, unassisted market. Rent must also not exceed the rent currently being charged by the owner for comparable, unassisted units. 24 CFR 574.320(a)(3)

	Proposed Property	Compared Property 1	Compared Property 2	Compared Property 3
Address				
Number of Bedrooms				
Square Feet				
Type of Property				
Property Condition				
Location/Accessibility				
Amenities Property: Site: Neighborhood:				
Age of Property (in Years)				
Property Rent (without utilities)				
Utility Allowance				
Gross Rent (rent plus utilities)				
Handicap Accessible				

Most Recent Rent for Property	$	Reason for Change (if applicable)	

*Other local resources may be used to obtain information (e.g. market surveys, classified ads, etc.)

I certify that I am not a HUD certified inspector and I have evaluated the property located at the above address to the best of my ability and find the following:

Rent Reasonableness Determination

A. Compliance with Payment Standard

_____ (Contract Rent) + _____ (Utility Allowance) = _____ (Proposed Gross Rent)

Approved rent does not exceed applicable Payment Standard of: $ _____

B. Rent Reasonableness

Based upon a comparison with rents for comparable units, I have determined that the proposed rent for _____ property IS $ _____ and IS NOT reasonable.

Printed Name	Signature	Date

Revised May 2021

Appendix A11

Public Housing Verification Worksheet and Instructions

1836 Lackland Hill Parkway St. Louis, MO 63146

To: Community Housing Services Worker or Case Manager
Community Housing Services Worker, please return form to client

Client Name_____ Social Security_____-_____-_____

This client must:

- Apply for any community housing resources he/she may be eligible for
- Maintain application status
- Provide 6- month updates on housing application status
- Accept any housing assistance that is offered

Please check the appropriate choice below:

___Applications not being accepted at this time

___Applicant does not qualify for housing assistance due to: _____

_____

___Initial application for community housing completed on _____/_____/_____ (date)

___Application is in process; client needs to provide the following additional documentation: (list below)

_____

_____

___Client is on housing waiting list. If on a housing waiting list, client is:

□ Currently number _____

□ Agency does not use a number system

Name of Community Housing Agency: _____

Name of Community Housing Services Worker confirming status (print): _____

Office Phone Number: (_____) _____-_____

Community Housing Services Worker Signature: _____ Date_____/____/_____
Or
Case Manager Signature: _____ _____ Date ____/____/_____

April 1, 2021

The Public Housing Verification form is used to confirm availability of housing resources and the client's status of eligibility for community-based housing programs. If the Public Housing application is available, please upload proof of application to the electronic client-level database. In the event the Case Manager is unable to retrieve written documentation from the Housing Authority, the Public Housing Verification form is an acceptable document. This form must be completed upon request for assistance unless the Public Housing Verification form has been completed within the past year or with any changes.

1. Community/Public Housing Services Worker or Case Manager is responsible for completing this form:
    a. If this form is given to the client for the Community/Public Housing Services Worker to complete, then the Case Manager must collect this form from the client once completed and scan it into the electronic client-level database
    b. Client Name- Name should be listed as the resident's (client's) legal name and must be consistent with the name entered in the Client Profile in the electronic client-level database.
    c. Client Social Security Number- Social Security number must have all nine numbers and must be consistent with the Client Profile in the electronic client-level database.
    d. Public Housing Availability and Client Eligibility Status- Check mark the appropriate choice of availability or status and enter a note, date, or number, where applicable. Verify with a check mark if the Community Housing Agency does not utilize or utilizes a number system and add the number given.
2. Community/Public Housing Agency Information must be collected to ensure that they have applied for all available community-based housing programs.
    a. The Community Housing Agency information and name of the worker verifying the information must be entered.
    b. Signature and Date are required from the Community/Public Housing Services Worker or Case Manager completing the form for this form to be acceptable.

Appendix A12

Housing Related Rights and Responsibilities

Housing Related Client Rights and Responsibilities

The following statements outline your rights and responsibilities for accessing housing services through the Ryan White Part B program.

I have a responsibility for the following:

- Provide a copy of the lease, prior to signing or moving into the property.
- Follow the terms of the lease agreement once all parties have signed the lease.
- Participate in the development of a plan of care to address my long-term housing stability.
- Allow the program to complete a housing inspection and rent reasonableness review prior to moving into the property to verify eligibility for assistance.
- Notify my Case Manager and Healthcare Strategic Initiatives (HSI) 30 days **prior** to moving to a new property.
- Maintain regular contact with my Case Manager and notify them of any changes in my income, household size, and/or living arrangements when they occur.
- Apply for and maintain active applications for local housing assistance programs.
- Provide true and accurate information pertaining to my eligibility for housing assistance.
- Provide all documentation to verify my eligibility in a timely manner.
- Pay the portion of housing costs over the amount of assistance I receive, including any amount of Fair Market Rent (FMR) and Rent Reasonableness standards.
- Pay my portion of rent, if any, as it is outlined in my lease agreement.
- Notify my Case Manager immediately if I am unable to pay my utilities.
- Take care of the property and leave it in the same condition as it was in prior to moving in.
- To **not** participate in any illegal activity in or outside of my residence. If I participate in illegal activity in or outside of my residence, I understand that I will no longer be eligible for housing assistance.

I have a right to the following:

- Receive timely, respectful services without regard to age, race, gender, disability, religion, sexual orientation, or whether I am a survivor of domestic violence, dating violence, sexual assault, or stalking.
- Receive copies of all signed documents pertaining to my housing services.
- Participate in the development of a plan of care to address my long-term housing stability.
- Receive an explanation of income calculations and factors used to determine the amount of assistance I am eligible to receive.
- Have my confidentiality maintained regarding my health conditions, but understand that my Case Manager and/or HSI may need to communicate with my landlord regarding documentation and financial assistance. Information regarding service eligibility will be shared on an “as needed” basis.
- Be informed of the terms and expectations of my housing assistance services and consequences if I do not comply with them.
- Appeal decisions through the Case Management grievance process.

I have read and understand the above statements regarding my rights and responsibilities for housing assistance. I understand that housing assistance is not permanent and availability may be limited if federal funding changes. I further acknowledge that failure to comply may result in suspension or termination of housing assistance.

Client Signature: _____ Date:_____

Appendix A13

VAWA Lease Addendum

LEASE ADDENDUM

VIOLENCE AGAINST WOMEN AND JUSTICE DEPARTMENT REAUTHORIZATION ACT OF 2005

TENANT	LANDLORD	UNIT NO. & ADDRESS

This lease addendum adds the following paragraphs to the Lease between the above referenced Tenant and Landlord.

Purpose of the Addendum

The lease for the above referenced unit is being amended to include the provisions of the Violence Against Women and Justice Department Reauthorization Act of 2005 (VAWA).

Conflicts with Other Provisions of the Lease

In case of any conflict between the provisions of this Addendum and other sections of the Lease, the provisions of this Addendum shall prevail.

Term of the Lease Addendum

The effective date of this Lease Addendum is _____. This Lease Addendum shall continue to be in effect until the Lease is terminated.

VAWA Protections

1. The Landlord may not consider incidents of domestic violence, dating violence or stalking as serious or repeated violations of the lease or other "good cause" for termination of assistance, tenancy or occupancy rights of the victim of abuse.
2. The Landlord may not consider criminal activity directly relating to abuse, engaged in by a member of a tenant's household or any guest or other person under the tenant's control, cause for termination of assistance, tenancy, or occupancy rights if the tenant or an immediate member of the tenant's family is the victim or threatened victim of that abuse.
3. The Landlord may request in writing that the victim, or a family member on the victim's behalf, certify that the individual is a victim of abuse and that the Certification of Domestic Violence, Dating Violence or Stalking, Form HUD-91066, or other documentation as noted on the certification form, be completed and submitted within 14 business days, or an agreed upon extension date, to receive protection under the VAWA. Failure to provide the certification or other supporting documentation within the specified timeframe may result in eviction.

_____ _____
Tenant Date

_____ _____
Landlord Date

Appendix A14

VAWA Certification of Domestic Violence, Dating Violence, Sexual Assault, or Stalking and Alternate Documentation Form

CERTIFICATION OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, OR STALKING, AND ALTERNATE DOCUMENTATION

U.S. Department of Housing and Urban Development

OMB Approval No. 2577-0286
Exp. 06/30/2017

Purpose of Form: The Violence Against Women Act ("VAWA") protects applicants, tenants, and program participants in certain HUD programs from being evicted, denied housing assistance, or terminated from housing assistance based on acts of domestic violence, dating violence, sexual assault, or stalking against them. Despite the name of this law, VAWA protection is available to victims of domestic violence, dating violence, sexual assault, and stalking, regardless of sex, gender identity, or sexual orientation.

Use of This Optional Form: If you are seeking VAWA protections from your housing provider, your housing provider may give you a written request that asks you to submit documentation about the incident or incidents of domestic violence, dating violence, sexual assault, or stalking.

In response to this request, you or someone on your behalf may complete this optional form and submit it to your housing provider, or you may submit one of the following types of third-party documentation:

(1) A document signed by you and an employee, agent, or volunteer of a victim service provider, an attorney, or medical professional, or a mental health professional (collectively, "professional") from whom you have sought assistance relating to domestic violence, dating violence, sexual assault, or stalking, or the effects of abuse. The document must specify, under penalty of perjury, that the professional believes the incident or incidents of domestic violence, dating violence, sexual assault, or stalking occurred and meet the definition of "domestic violence," "dating violence," "sexual assault," or "stalking" in HUD's regulations at 24 CFR 5.2003.

(2) A record of a Federal, State, tribal, territorial or local law enforcement agency, court, or administrative agency; or

(3) At the discretion of the housing provider, a statement or other evidence provided by the applicant or tenant.

Submission of Documentation: The time period to submit documentation is 14 business days from the date that you receive a written request from your housing provider asking that you provide documentation of the occurrence of domestic violence, dating violence, sexual assault, or stalking. Your housing provider may, but is not required to, extend the time period to submit the documentation, if you request an extension of the time period. If the requested information is not received within 14 business days of when you received the request for the documentation, or any extension of the date provided by your housing provider, your housing provider does not need to grant you any of the VAWA protections. Distribution or issuance of this form does not serve as a written request for certification.

Confidentiality: All information provided to your housing provider concerning the incident(s) of domestic violence, dating violence, sexual assault, or stalking shall be kept confidential and such details shall not be entered into any shared database. Employees of your housing provider are not to have access to these details unless to grant or deny VAWA protections to you, and such employees may not disclose this information to any other entity or individual, except to the extent that disclosure is: (i) consented to by you in writing in a time-limited release; (ii) required for use in an eviction proceeding or hearing regarding termination of assistance; or (iii) otherwise required by applicable law.

TO BE COMPLETED BY OR ON BEHALF OF THE VICTIM OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, OR STALKING

1. **Date the written request is received by victim:** _____

2. **Name of victim:** _____

3. **Your name (if different from victim's):**_____

4. **Name(s) of other family member(s) listed on the lease:**_____

_____

5. **Residence of victim:** _____

6. **Name of the accused perpetrator (if known and can be safely disclosed):**_____

_____

7. **Relationship of the accused perpetrator to the victim:**_____

8. **Date(s) and times(s) of incident(s) (if known):**_____
_____

10. **Location of incident(s):**_____

In your own words, briefly describe the incident(s):

_____

_____

_____

_____

This is to certify that the information provided on this form is true and correct to the best of my knowledge and recollection, and that the individual named above in Item 2 is or has been a victim of domestic violence, dating violence, sexual assault, or stalking. I acknowledge that submission of false information could jeopardize program eligibility and could be the basis for denial of admission, termination of assistance, or eviction.

Signature _____Signed on (Date) _____

Public Reporting Burden: The public reporting burden for this collection of information is estimated to average 1 hour per response. This includes the time for collecting, reviewing, and reporting the data. The information provided is to be used by the housing provider to request certification that the applicant or tenant is a victim of domestic violence, dating violence, sexual assault, or stalking. The information is subject to the confidentiality requirements of VAWA. This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid Office of Management and Budget control number.

Appendix A15

VAWA Notice of Occupancy Rights

U.S. Department of Housing and Urban Development
OMB Approval No. 2577-0286
Expires 06/30/2017

[Landlord Name]

Notice of Occupancy Rights under the Violence Against Women Act[1]

To all Tenants and Applicants

The Violence Against Women Act (VAWA) provides protections for victims of domestic violence, dating violence, sexual assault, or stalking. VAWA protections are not only available to women but are available equally to all individuals regardless of sex, gender identity, or sexual orientation.[2] The U.S. Department of Housing and Urban Development (HUD) is the Federal agency that oversees that **Department of Health and Senior Services (DHSS) Benefits Administrator** is in compliance with VAWA. This notice explains your rights under VAWA. A HUD-approved certification form is attached to this notice. You can fill out this form to show that you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking and that you wish to use your rights under VAWA."

Protections for Applicants

If you otherwise qualify for assistance under **DHSS Benefits Administrator,** you cannot be denied admission or denied assistance because you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking.

Protections for Tenants

If you are receiving assistance under **DHSS Benefits Administrator,** you may not be denied assistance, terminated from participation, or be evicted from your rental housing because you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking.

Also, if you or an affiliated individual of yours is or has been the victim of domestic violence, dating violence, sexual assault, or stalking by a member of your household or any guest, you may not be denied rental assistance or occupancy rights under **DHSS Benefits Administrator** solely on the basis of criminal activity directly relating to that domestic violence, dating violence, sexual assault, or stalking.

Affiliated individual means your spouse, parent, brother, sister, or child, or a person to whom you stand in the place of a parent or guardian (for example, the affiliated individual is in your care, custody, or control); or any individual, tenant, or lawful occupant living in your household.

Removing the Abuser or Perpetrator from the Household

[Landlord Name] may divide (bifurcate) your lease in order to evict the individual or terminate the assistance of the individual who has engaged in criminal activity (the abuser or perpetrator) directly relating to domestic violence, dating violence, sexual assault, or stalking.

If **[Landlord Name]** chooses to remove the abuser or perpetrator, **[Landlord Name]** may not take away the rights of eligible tenants to the unit or otherwise punish the remaining tenants. If the evicted abuser or perpetrator was the sole tenant to have established eligibility for assistance under the program, **[Landlord Name]** must allow the tenant who is or has been a victim and

[1] Despite the name of this law, VAWA protection is available regardless of sex, gender identity, or sexual orientation.

[2] Housing providers cannot discriminate on the basis of any protected characteristic, including race, color, national origin, religion, sex, familial status, disability, or age. HUD-assisted and HUD-insured housing must be made available to all otherwise eligible individuals regardless of actual or perceived sexual orientation, gender identity, or marital status.

other household members to remain in the unit for a period of time, in order to establish eligibility under the program or under another HUD housing program covered by VAWA, or, find alternative housing.

In removing the abuser or perpetrator from the household, **[Landlord Name]** must follow Federal, State, and local eviction procedures. In order to divide a lease, **[Landlord Name]** may, but is not required to, ask you for documentation or certification of the incidences of domestic violence, dating violence, sexual assault, or stalking.

Moving to Another Unit

Upon your request, **[Landlord Name]** may permit you to move to another unit, subject to the availability of other units, and still keep your assistance. In order to approve a request, **[Landlord Name]** may ask you to provide documentation that you are requesting to move because of an incidence of domestic violence, dating violence, sexual assault, or stalking. If the request is a request for an emergency transfer, the housing provider may ask you to submit a written request or fill out a form where you certify that you meet the criteria for an emergency transfer under VAWA. The criteria are:

(1) You are a victim of domestic violence, dating violence, sexual assault, or stalking. If your housing provider does not already have documentation that you are a victim of domestic violence, dating violence, sexual assault, or stalking, your housing provider may ask you for such documentation, as described in the documentation section below.

(2) You expressly request the emergency transfer. Your housing provider may choose to require that you submit a form or may accept another written or oral request.

(3) You reasonably believe you are threatened with imminent harm from further violence if you remain in your current unit. This means you have a reason to fear that if you do not receive a transfer, you will suffer violence in the very near future.

OR

You are a victim of sexual assault, and the assault occurred on the premises during the 90-calendar-day period before you request a transfer. If you are a victim of sexual assault, then in addition to qualifying for an emergency transfer because you reasonably believe you are threatened with imminent harm from further violence if you remain in your unit, you may qualify for an emergency transfer if the sexual assault occurred on the premises of the property from which you are seeking your transfer, and that assault happened within the 90-calendar-day period before you expressly request the transfer.

[Landlord Name] will keep confidential requests for emergency transfers by victims of domestic violence, dating violence, sexual assault, or stalking, and the location of any move by such victims and their families.

[Landlord Name]'s emergency transfer plan provides further information on emergency transfers, and **[Landlord Name]** must make a copy of its emergency transfer plan available to you if you ask to see it.

Documenting You Are or Have Been a Victim of Domestic Violence, Dating Violence, Sexual Assault or Stalking

[Landlord Name] can, but is not required to, ask you to provide documentation to "certify" that you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking. Such request from **[Landlord Name]** must be in writing, and **[Landlord Name]** must give you at least 14 business days (Saturdays, Sundays, and Federal holidays do not count) from the day you receive the request to provide the documentation. **[Landlord Name]** may, but does not have to, extend the deadline for the submission of documentation upon your request.

You can provide one of the following to **[Landlord Name]** as documentation. It is your choice which of the following to submit if **[Landlord Name]** asks you to provide documentation that you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking.

- A complete HUD-approved certification form given to you by **[Landlord Name]** with this notice that documents an incident of domestic violence, dating violence, sexual assault, or stalking. The form will ask for your name, the date, time, and location of the incident of domestic violence, dating violence, sexual assault, or stalking, and a description of the incident. The certification form provides for including the name of the abuser or perpetrator if the name of the abuser or perpetrator is known and is safe to provide.
- A record of a Federal, State, tribal, territorial, or local law enforcement agency, court, or administrative agency that documents the incident of domestic violence, dating violence, sexual assault, or stalking. Examples of such records include police reports, protective orders, and restraining orders, among others.
- A statement, which you must sign, along with the signature of an employee, agent, or volunteer of a victim service provider, an attorney, a medical professional or a mental health professional (collectively, "professional") from whom you sought assistance in addressing domestic violence, dating violence, sexual assault, or stalking, or the effects of abuse, and with the professional selected by you attesting under penalty of perjury that he or she believes that the incident or incidents of domestic violence, dating violence, sexual assault, or stalking are grounds for protection.
- Any other statement or evidence that **[Landlord Name]** has agreed to accept.

If you fail or refuse to provide one of these documents within 14 business days, **[Landlord Name]** does not have to provide you with the protections contained in this notice.

If **[Landlord Name]** receives conflicting evidence that an incident of domestic violence, dating violence, sexual assault, or stalking has been committed (such as certification forms from two or more members of a household, each claiming to be a victim and naming one or more of the other petitioning household members as the abuser or perpetrator), **[Landlord Name]** has the right to request that you provide third-party documentation within thirty 30 calendar days in order to resolve the conflict. If you fail or refuse to provide third-party documentation where there is conflicting evidence, **[Landlord Name]** does not have to provide you with the protections contained in this notice.

Confidentiality

[Landlord Name] must keep confidential any information you provide related to the exercise of your rights under VAWA, including the fact that you are exercising your rights under VAWA.

[Landlord Name] must not allow any individual administering assistance or other services on behalf of HP (for example, employees and contractors) to have access to confidential information unless for reasons that specifically call for these individuals to have access to this information under applicable Federal, State, or local law.

[Landlord Name] must not enter your information into any shared database or disclose your information to any other entity or individual. **[Landlord Name]**, however, may disclose the information provided if:

- You give written permission to **[Landlord Name]** to release the information on a time-limited basis.
- **[Landlord Name]** needs to use the information in an eviction or termination proceeding, such as to evict your abuser or perpetrator or terminate your abuser or perpetrator from assistance under this program.
- A law requires **[Landlord Name]** or your landlord to release the information.

VAWA does not limit **[Landlord Name]**'s duty to honor court orders about access to or control of the property. This includes orders issued to protect a victim and orders dividing property among household members in cases where a family breaks up.

Reasons a Tenant Eligible for Occupancy Rights under VAWA May Be Evicted or Assistance May Be Terminated

You can be evicted, and your assistance can be terminated for serious or repeated lease violations that are not related to domestic violence, dating violence, sexual assault, or stalking committed against you. However, **[Landlord Name]** cannot hold tenants who have been victims of domestic violence, dating violence, sexual assault, or stalking to a more demanding set of rules than it applies to tenants who have not been victims of domestic violence, dating violence, sexual assault, or stalking.

The protections described in this notice might not apply, and you could be evicted and your assistance terminated, if **[Landlord Name]** can demonstrate that not evicting you or terminating your assistance would present a real physical danger that:

1) Would occur within an immediate time frame, and
2) Could result in death or serious bodily harm to other tenants or those who work on the property.

If **[Landlord Name]** can demonstrate the above, **[Landlord Name]** should only terminate your assistance or evict you if there are no other actions that could be taken to reduce or eliminate the threat.

Other Laws

VAWA does not replace any Federal, State, or local law that provides greater protection for victims of domestic violence, dating violence, sexual assault, or stalking. You may be entitled to additional housing protections for victims of domestic violence, dating violence, sexual assault, or stalking under other Federal laws, as well as under State and local laws.

Non-Compliance with The Requirements of This Notice
You may report a covered housing provider's violations of these rights and seek additional assistance, if needed, by contacting or filing a complaint with the HUD Kansas City Regional Office at 400 State Avenue Rm 200, Kansas City, KS 66101 or by phone at (913) 551-5462.

For Additional Information
You may view a copy of HUD's final VAWA rule at https://www.govinfo.gov/content/pkg/PLAW-113publ4/pdf/PLAW-113publ4.pdf.

Additionally, **[Landlord Name]** must make a copy of HUD's VAWA regulations available to you if you ask to see them.

For questions regarding VAWA, please contact your Case Manager.

For help regarding an abusive relationship, you may call the National Domestic Violence Hotline at 1-800-799-7233 or, for persons with hearing impairments, 1-800-787-3224 (TTY). You may also contact **[Insert contact information for relevant local organizations]**.

For tenants who are or have been victims of stalking seeking help may visit the National Center for Victims of Crime's Stalking Resource Center at https://www.victimsofcrime.org/our-programs/stalking-resource-center.

For help regarding sexual assault, you may contact **[Insert contact information for relevant organizations]**

Victims of stalking seeking help may contact **[Insert contact information for relevant organizations]**.

Attachment: Certification form HUD-5382 **[form approved for this program to be included]**

Appendix A16

Family Verification of Demonstrated Need Form

Family Verification of Demonstrated Need

Client Name:		**Client DCN:**	
Client Address:		**Client Telephone:**	
Family Member Name:		**Family Member Telephone:**	
Family Member Relationship to Client:			

Services

The family member named above agrees to provide assistance with all activities of daily living checked below.

- ☐ Walking independently or moving from one position to another
- ☐ Feeding oneself
- ☐ Dressing
- ☐ Personal Hygiene (including dental, nail, and hair care)
- ☐ Continence
- ☐ Toileting (ability to get to/from a toilet, use toilet appropriately, and cleaning oneself)
- ☐ Transportation
- ☐ Shopping for essential items (e.g. groceries, clothing, medical supplies, etc.)
- ☐ Meal preparation (including preparing food, cooking, and putting meal on table)
- ☐ House cleaning and home maintenance (cleaning after meal preparation and eating, maintaining clean/tidy residence, and regular home maintenance)
- ☐ Managing communication with others (including postal mail and telephone communication)
- ☐ Managing medications (ability to obtain medications and take as directed)

Family Member Signature:		**Date:**	

I attest that the above my family member listed above assists me with all of the activities of daily living that are checked above.

Client Signature:		**Date:**	

Appendix A17

Physician Verification of Demonstrated Need Form

Physician Verification of Demonstrated Need

Client Name:		**Client DCN:**	
Client Address:		**Client Telephone:**	
Physician Name:		**Physician Telephone:**	
Physician Office Address:			
Family Member Name:		**Family Member Telephone:**	
Family Member Relationship to Client:			

Activities of Daily Living: Based on my assessment of the client's health, the client requires assistance with the checked activities of daily living below.

- ☐ Walking independently or moving from one position to another
- ☐ Feeding oneself
- ☐ Dressing
- ☐ Personal Hygiene (including dental, nail, and hair care)
- ☐ Continence
- ☐ Toileting (ability to get to/from a toilet, use toilet appropriately, and cleaning oneself)
- ☐ Transportation
- ☐ Shopping for essential items (e.g. groceries, clothing, medical supplies, etc.)
- ☐ Meal preparation (including preparing food, cooking, and putting meal on table)
- ☐ House cleaning and home maintenance (cleaning after meal preparation and eating, maintaining clean/tidy residence, and regular home maintenance)
- ☐ Managing communication with others (including postal mail and telephone communication)
- ☐ Managing medications (ability to obtain medications and take as directed)

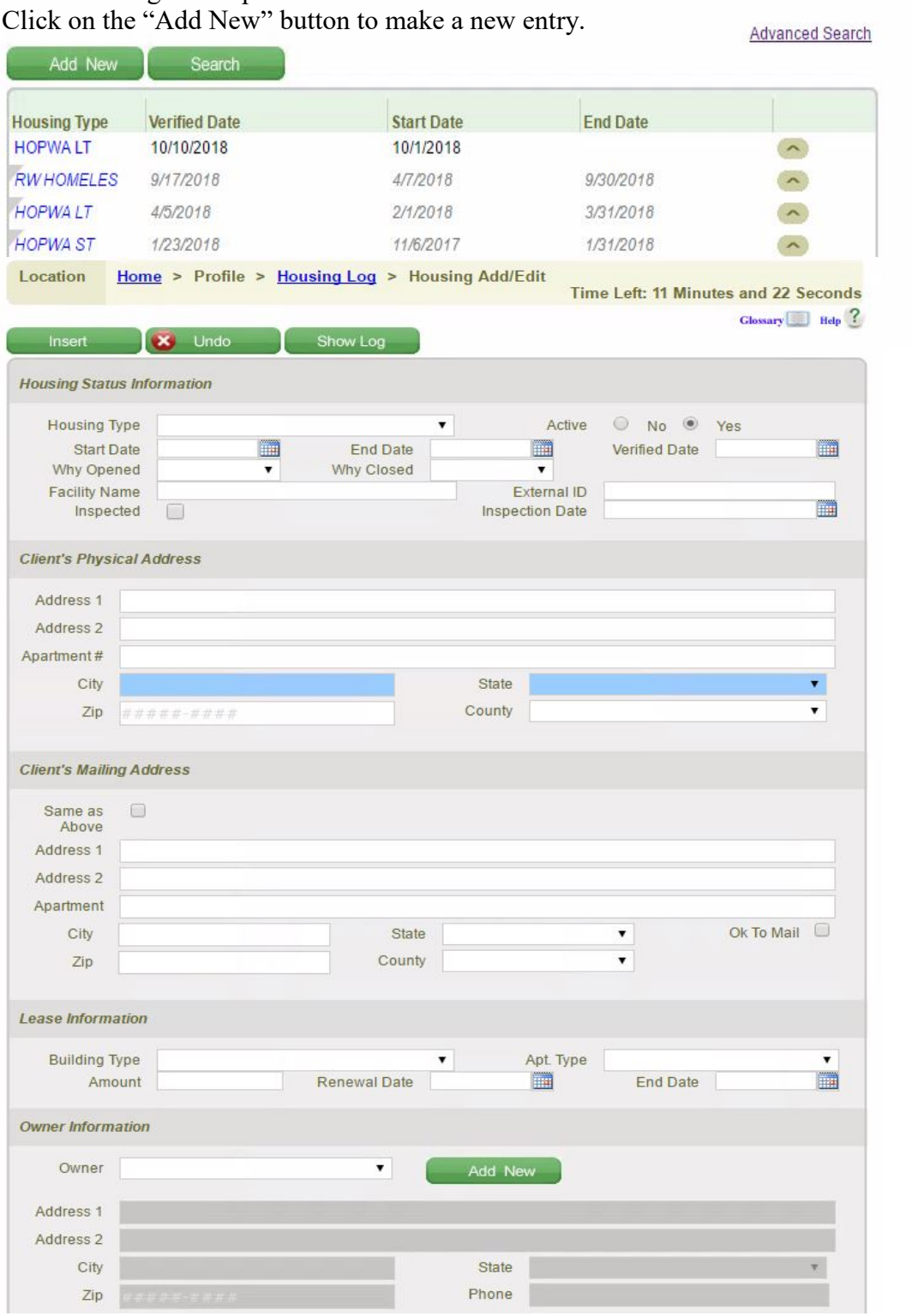
Physician Name (Please Print)**:**			
Physician Signature:		**Date:**	

Appendix B1

Outstate Services Data Rules

Housing Module

1. The Housing Module will be completed when a client is entering or exiting the program.
2. Click Housing on the profile tab of the SCOUT menu.
3. Click on the "Add New" button to make a new entry.



4. Select "Housing Type" from the drop-down menu in the Housing Module section. (See the table below for housing type selections)

Housing Type	**Description**
HOPWA LT-HOPWA	Long-term (tenant based rental assistance)
HOPWA ST-HOPWA	Short-term (rent, mortg., util pmts.)
PS DPT COR-Positive Start	Dept. of Corrections Facility
RW HOMELESS-Ryan White	Curr. Lvg. Arr.=Homeless
RW INST-Ryan White	Curr. Lvg. Arr.=Institution
RW N-PERM-Ryan White	Curr. Lvg. Arr=Non-pem. Housed
RW OMO-Ryan White	Curr. Lvg. Arr=OMO
RW Other-Ryan White	Curr. Lvg. Arr=Other
RW PERM-Ryan White	Curr. Lvg. Arr.=Permanently Housed
RW Public-Ryan White	Curr. Lvg. Arr.=Public Housing
RW SEC8-Ryan White	Curr. Lvg. Arr.=Section 8
RW SEN&DIS-Ryan White	Curr. Lvg. Arr.=Senior & Disabled
RW SPLUSC-Ryan White	Curr. Lvg. Arr.=Shelter Plus Care

5. Select "Why Opened" or "Why Closed" from the drop down menu in the Housing Module section. (See the table below for why opened/why closed selections.)

Why Closed	**Description**
HPW01VOLUN	Emergency Shelter/Streets
HPW01XCINC	Temporary Housing
HPW02NONPT	Other HOPWA
HPW03SSNON	Other Subsidy
HPW04CRIML	Jail/Prison
HPW05DEATH	Death
HPW06UNKWN	Disconnected/Unknown
HPW07OTHER	Remove access
HPW08MVD	Private Housing

6. Enter all of the following fields in the "Housing Status Information" in the Housing Module section.
    a. Select the appropriate "Housing Type" from the drop-down menu.
    b. Choose "Yes" next to the "Active" radial button.
    c. Insert the date that the client started living at this location.
    d. Insert the date that the Case Manager verified the client's residency.
    e. In the "Why Opened or Closed" field, select the appropriate reason for opening the record for the client. (If this is for a new entry)
    f. Put a check in the "Inspected" box if the unit has been inspected.
    g. If the unit has been inspected, insert the date of the inspection in the "Inspection Date" field.

7. Enter all of the following fields in the "Client's Physical Address" section.
    a. Type the Street address for the client's residence.
    b. If applicable, insert information such as "Attention to:" or the second line of the client's address in the "Address 2" field.
    c. Type the client's apartment or unit number in the "Apartment" field. Case Managers **must** type "Apt," "Unit," "Floor," etc., before the unit number.
        i. When entering address information use correct lower/upper case letters and proper punctuation.
    d. In the "City" field, type the name of the city the client resides in
    e. In the "State" field, type "MO" for Missouri, unless the client lives in another state, then type that state's abbreviation.
    f. Type the city's zip code in the "Zip" field
    g. Choose the county the client resides in from the "County" drop-down menu.

8. Enter all of the following fields in the Client's Mailing Address section.
    a. If the mailing address is the same as the client's physical address, check the box "Same as Above."
    b. If the client's mailing address is different from the client's physical address, follow the same instructions for the "Client's Physical Address" section.

9. Enter all of the following information in the "Lease Information" section.
    a. Insert the type of building/Choose the appropriate type of building in the "Building Type" field.
    b. In the "Apt. Type" field, select the appropriate/type of apartment the client resides in.
    c. In the "Amount" field, type the monthly payment amount that the client pays for rent or mortgage.

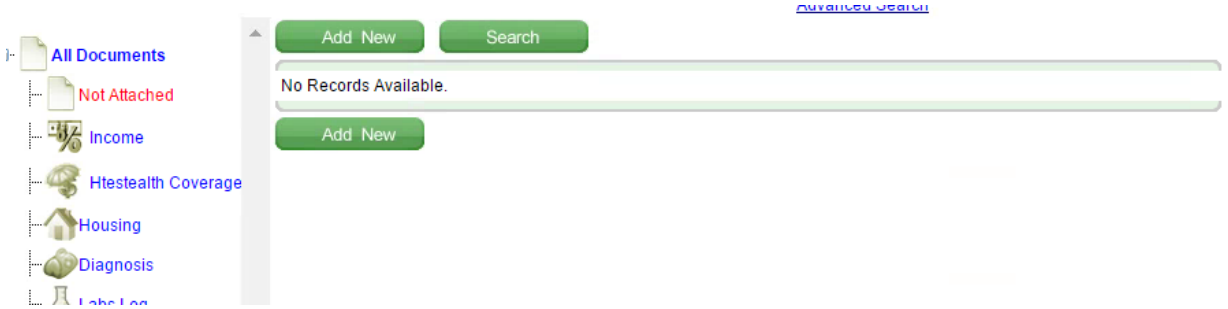
10. Enter all the following information in the "Owner Information" section.
    a. In the "Owner" field, choose the appropriate selection from the drop-down box.
    b. If the owner is not listed contact your SCOUT Liaison to complete a ticket.

11. Click on the "Update" button.

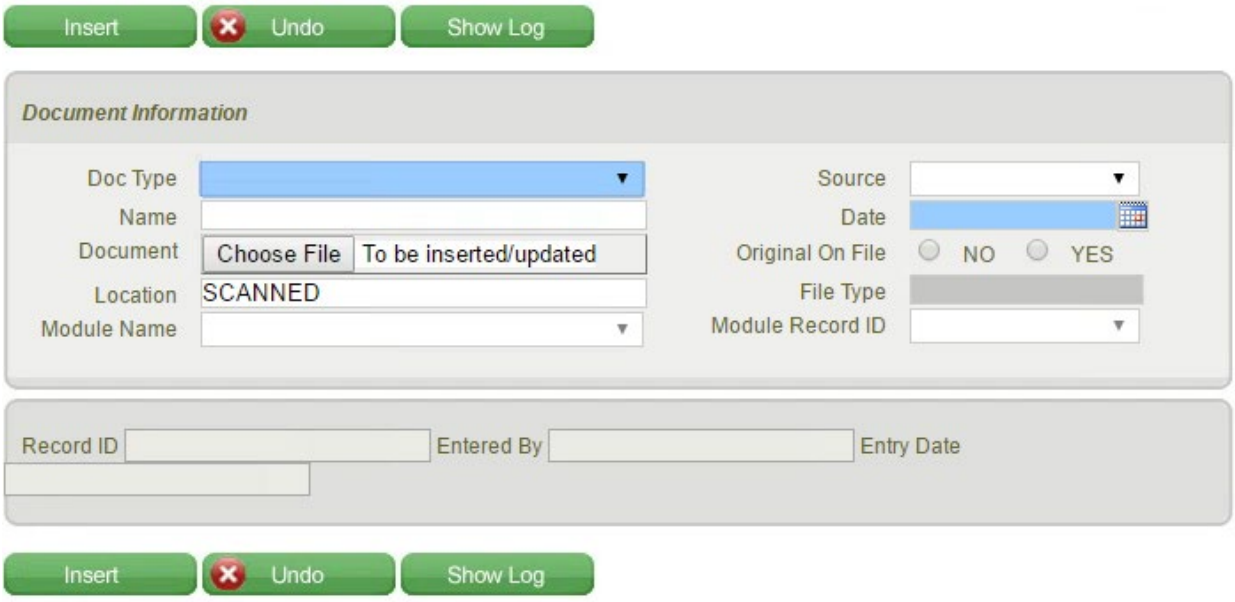
Documents Module

Clients must provide documentation to support their eligibility and need for services. Below is a table of types of documents that can be uploaded to support the client's eligibility as needed.

1. Click on documents in the profile tab of the SCOUT menu, then click on "Add New."



2. Fill out the following fields in the "Document Information" section.
   a. In the "Doc Type," select the appropriate type of document from the drop-down list.
   b. In the "Source" field, select the appropriate choice from the drop-down list if available.
   c. In the "Name" field, give the document an appropriate name/title.
   d. In the "Date" field, insert the date the document is uploaded into SCOUT.
   e. Click on "Choose File" in the "Document" field. Then search for the appropriate document for upload.
   f. Choose the appropriate radial button in the "Original on File."



3. Click on the "Insert" button.

Document Types
ACA – AE Pre-application with signature
ACA – Documentation
Additional Assessment Data
Agency Client Service Request Form
Case Consultation
Client Doc – Birth Certificate
Client Doc – Driver's License/State ID
Client Doc – Healthcare Directives/Durable POA
Client Doc – Immigration Documentation
Client Doc – Medical records
Client Doc – Social Security Card
Client Doc – Will
Client File Sharing Consent
CM Service Agreement (Data Sheet)
Community Referrals
Copy of birth certificate if bill in minor chds nm
Correspondence
Documentation of Medical Visit
Exception Request
Grievance Policy
Health Coverage – Change Release Form/EFT Term.
Health Coverage – HSI Card
Health Coverage – HSI Release for Insurance (2)
Health Coverage – Insurance Cont./COBRA
Health Coverage – Insurance Eligibility Letter
Health Coverage – Letter of Creditable Coverage
Health Coverage – Medicaid Card
Health Coverage – Medical Bills/EOBs
Health Coverage – Medicare A & B
Health Coverage – Medicare Part A
Health Coverage – Medicare Part B
Health Coverage – Medicare Part C
Health Coverage – Medicare Part D
Health Coverage – Private Insurance Documentation
HICP Client Refund(s)
HIPAA Release
HOPWA Enrollment Form
Housing – Assistance Notification Form
Housing – Assistance Verification Form
Housing – Community Housing App./Verification
Housing – Criminal Background Check
Housing – Family Verification of Demonstrated Need

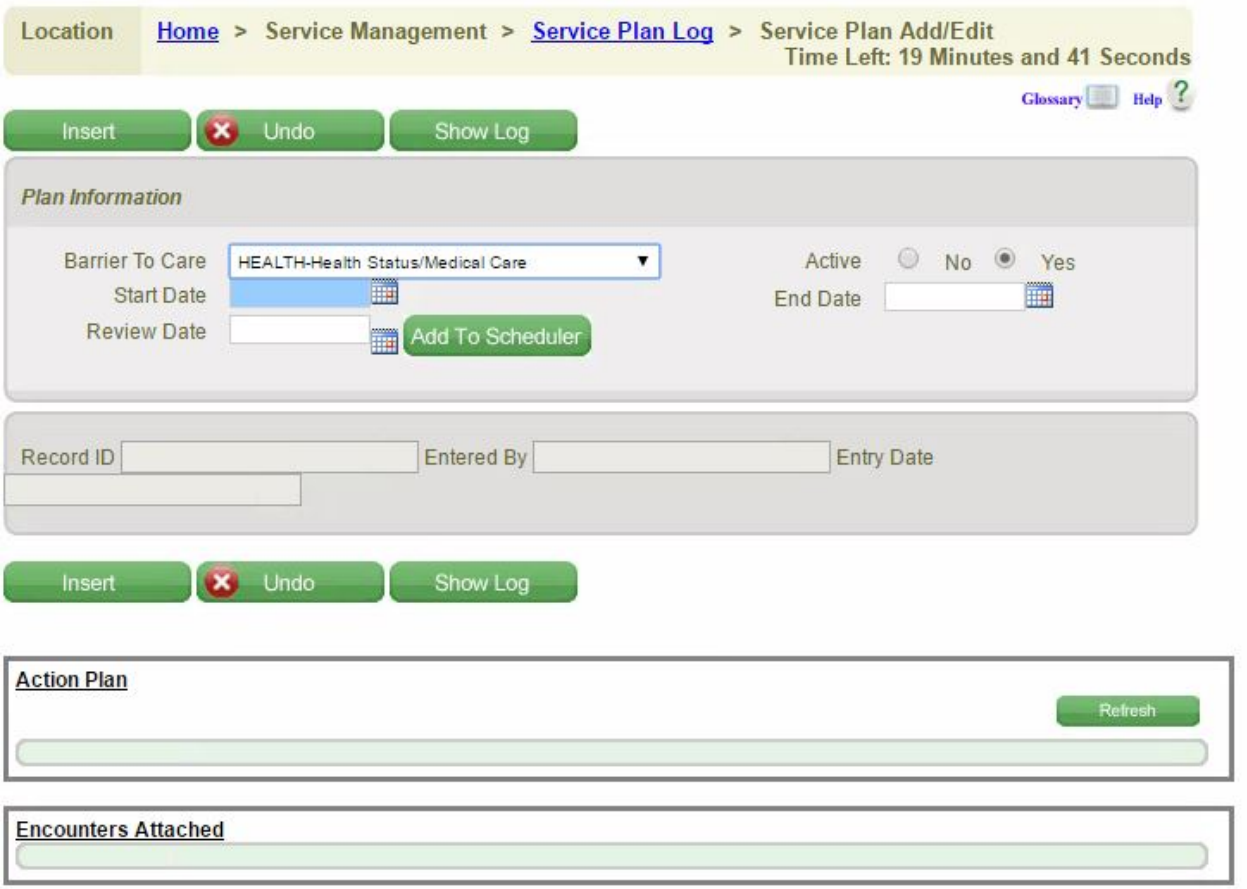
Document Types
Housing – HOPWA Inspection Form
Housing – Lead-Based Paint Disclosure Form
Housing – Lease
Housing – Mortgage Payment/Verification
Housing – Other
Housing – Physician Verification of Demonstrated Need
Housing – Rent Reasonableness Checklist
Housing – Rights and Responsibilities
Housing – Utility Asst. Calculation Worksheet
Housing – Utility Bill
Housing – VAWA Domestic Violence Certification
Housing – VAWA Lease Addendum
Housing – VAWA Notice of Occupancy Rights
Housing – W-9 Taxpayer ID Number
HSI Client Correspondence
LTC Data Sheet
Marriage Certificate
MCM – Budget Planner
MCM – Emergency Preparedness and Response Form
MCM – Income Determination Form
MCM – Intake Form
MCM – Release – Other (Description in Name Field)
MCM – Release OF PHI (Description in Name Field)
MCM – Signature Page
Missouri Medicaid Screening Tool
MO ADAP Affidavit of Declined Insurance form
OMO Award Letter
Positive Start – attachment
Positive Start – CMS Referral Form
Positive Start – What You Need to Know MO Law
Proof of Food Stamps
Resource/Care Plan
SPPC Waiver Client Choice Statement
SPPC Waiver Emergency Plan
SPPC Waiver HIVLOC
SPPC Waiver Medicaid Authorization Deter. Letter
SPPC Waiver Notification of Change Letter
SPPC Waiver Personal Goal Plan
SPPC Waiver QSM Plan Approval
SPPC Waiver Service Activity Instructions
SPPC Waiver Service Plan
SPPC Waiver Supervisory Monitoring Log

Document Types (continued)
TCM STEP documents
Transportation Request
Treatment Adherence – Care Plan
Treatment Adherence – Intake
Treatment Adherence – Notes/Discharge
Treatment Education Certificate
Verification Medigap Supplement Insurance
Verification of Community Housing Application
Verification of HIV+ Status
Verification of Incarceration

Document Types (continued)
Verification of Income
Verification of Income/Residency
Verification of Legal Name Change
Verification of Medicaid Application
Verification of Medicaid Denial
Verification of Medical Status
Verification of Preliminary Positive
Verification of Residency
X Other (Enter description in Name Field)

Service Plan Module

1. Click on "Service Management" in the profile tab of the SCOUT menu
2. Click on the "Service Plan" button
3. Click the "Add New" button



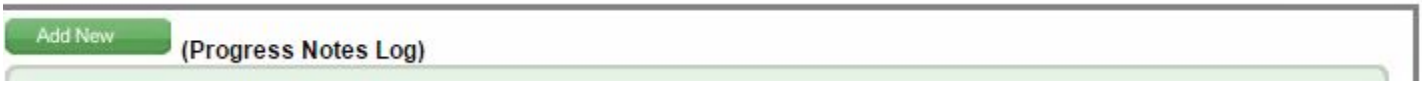
4. Select FINANCIAL-Housing/Living Situation from the area of assessment drop-down menu. (See the table below for Areas of Assessment options.)

Areas of Assessment
HEALTH-Health Status/Medical Care
HEALTH-Adherence (Medication & Treatment)
HEALTH-Oral Health
HEALTH-Mental Health
HEALTH-Substance Abuse
HEALTH-Risk Reduction
HEALTH-HIV Knowledge
HEALTH-Activities of Daily Living (ADLs)

Areas of Assessment
SOCIAL-Social Support System/Primary Relationships
SOCIAL-Intimate Partner Violence (IPV)/Trauma
SOCIAL-Legal
SOCIAL-Culture/Language
FINANCIAL-Financial/Health Benefits
FINANCIAL-Transportation
FINANCIAL-Housing/Living Situation
SELF-DETERMINATION-Self-Determination & Goal-Setting

5. Select Active "No or Yes"
6. Insert the date the area of assessment began in the "Start Date" field.
7. In the "Review Date" field, insert the date that the area of assessment was last reviewed with the client.
8. Select insert.
9. Once inserted, the Case Manager must insert a note explaining the client's area of assessment/need.
10. Click "Add New" in the "Progress Note" section.
11. Using the MO CM Service Plan clipping, describe the need/goal for each Areas of Assessment item to be in the Service Plan or detail past or current efforts. Include the actions needed (who, what, by when) to achieve success toward meeting the client's need/goal
12. Click Insert.
13. Leave the action plan blank. Instead, the Case Manager must attach an encounter to the specific area of assessment explaining the housing needs and how the client plans to reduce expenses to increase their income.

Progress Notes Log



1. Click "Add New" in the "Progress Note" section.
2. Using the MO CM Service Plan clipping, describe the need/goal for each Areas of Assessment item to be in the Service Plan or detail past or current efforts. Include the actions needed (who, what, by when) to achieve success toward meeting the client's need/goal
3. Click Insert.

Action Plan

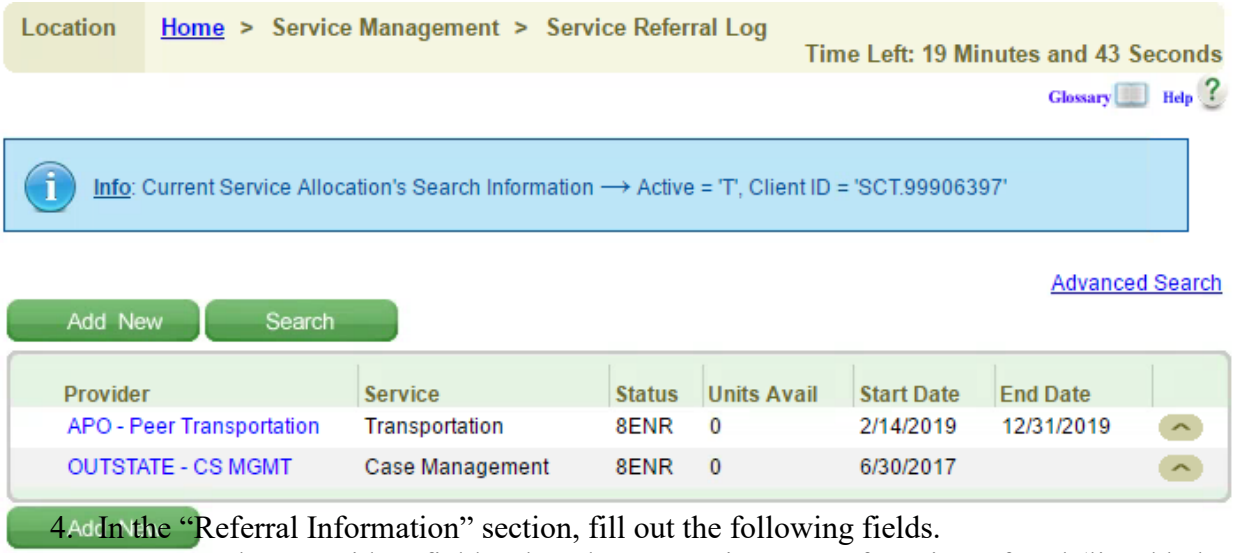
1. Leave the action plan blank. Instead, the Case Manager must attach an encounter to the specific area of assessment explaining the housing needs and how the client plans to reduce expenses to increase their income.

Service Referrals Module

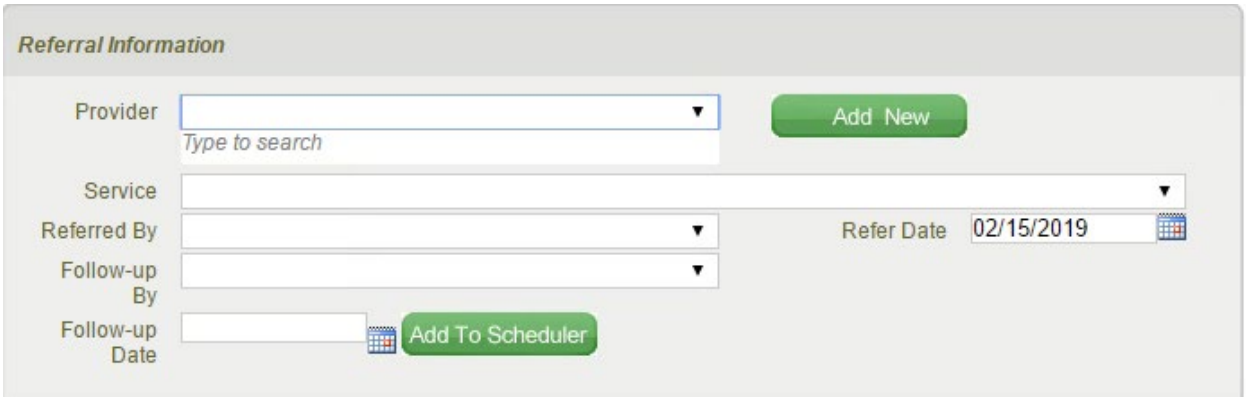
Clients who are receiving services should have an active service referral for one or more of the services listed below. Detailed descriptions of service referrals are in Appendix C7.

Complete a new service referral entry using the following steps:

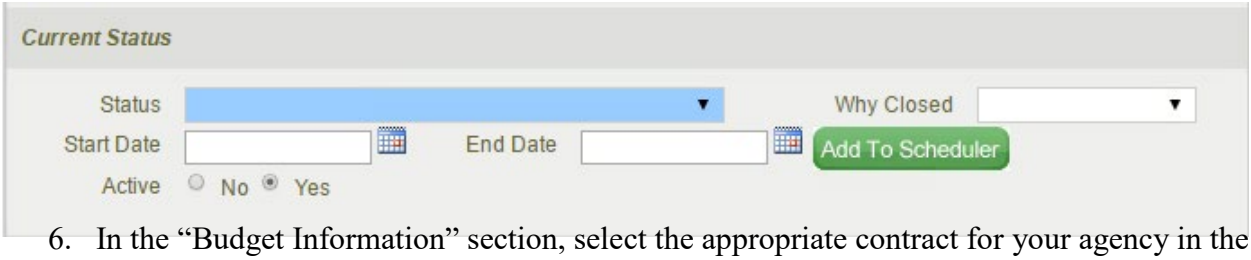
1. Click on "Service Management" in the profile tab of the SCOUT menu.
2. Click on the "Service Referral"
3. Click "Add New" button.



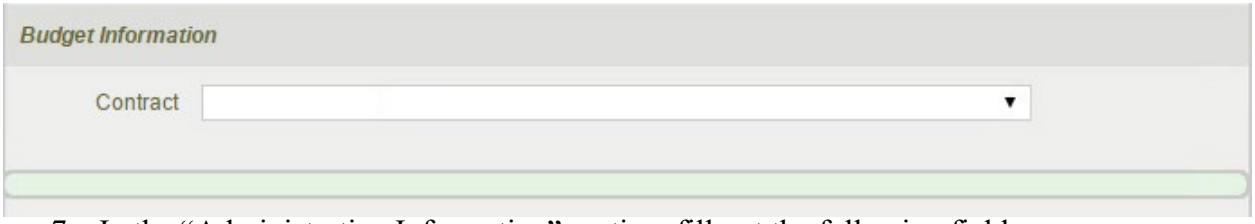
4. In the "Referral Information" section, fill out the following fields.
   a. In the "Provider" field, select the appropriate type of service referral (listed below, or Appendix C7).
   b. Choose the provided option in the "Service" field
   c. In the "Referred By" drop-down field, choose your name.
   d. If necessary, select the appropriate person from the "Follow-Up By" drop-down field and insert a date into the "Follow-Up Date" field.



5. In the "Current Status" section, fill out the following fields.
   a. In the "Status" drop-down field, select "1RFR-Referral Made" unless directed otherwise.
   b. Insert the first date of client eligibility for the service in the "Start Date" field.



6. In the "Budget Information" section, select the appropriate contract for your agency in the "Contract" drop-down menu.



7. In the "Administrative Information" section, fill out the following fields.
    a. Select your agency name in the "Site" field.
    b. In the "Program" field, select the appropriate region for the client. This should match the "Region" field to the left.

8. Click the "Insert" button.

Service Referral Types
HSI – ADAP Program/Medications
HSI – Ambulatory/Outpatient Medical Care
HSI – Ambulatory/Outpatient Medical Care Co-pays
HSI – Dental
HSI – Dental Co-pays
HSI – Emer. Fin. Asst – General/Other
HSI – Health Insurance Continuation
HSI – Housing Srvs/Hopwa/Mortgage Asst
HSI – Housing Srvs/HOPWA/Rental Subsidy
HSI – Housing Srvs/RW/Rental Subsidy

Service Referral Types
HSI – Housing Srvs/RW/Deposit Services
HSI – Mental Health Counseling
HSI – Mental Health Counseling Co-pays
HSI – Spenddown/Ticket to Work Assistance
HSI – Substance Abuse Treatment Services
HSI – Substance Abuse Treatment Services Co-pays
HSI – Transportation
HSI – Utilities
HSI – Utility Deposit

Appendix C1

Outstate Terminology and Definitions

1. **Communicate** is an electronic client database message that is sent to another user who needs knowledge of requests or changes to services.
2. **Department for Housing and Urban Development (HUD)** is responsible for national policy and programs that address America's housing needs, that improve and develop the Nation's communities and enforce fair housing laws. www.hud.gov
3. **Fair Market Rent (FMR)** is the amount that would be needed to pay the gross rent (rent plus utilities, except telephone) of privately owned, decent, safe, and sanitary rental housing of a modest (non-luxury) nature with suitable amenities
4. **Family:** All persons living in the same household who are related by birth, marriage, or adoption. (https://archives.huduser.gov/portal/glossary/glossary.html)
5. **Health Resources and Services Administration (HRSA) Ryan White (RW) HIV/AIDS Program** provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV. https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program
6. **Household:** All the people who occupy a housing unit. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit, such as partners or roomers, is also counted as a household. (https://archives.huduser.gov/portal/glossary/glossary.html)
7. **Housing Inspections** are a non-professional, visual inspection of the housing unit that requires no specialized training or skills and is performed by the case manager at the client's initial move into a unit and annually for clients remaining in the same unit.
8. **Housing Quality Standards** are used to set minimum standards to protect the health and safety of the residents, including the following components:
    a. The structure must be sound and not pose any threat or hazard to the health and safety of the residents.
    b. Properties must meet all applicable local codes and not be deemed unsafe or unsanitary. (https://nchh.org/information-and-evidence/healthy-housing-policy/state-and-local/healthy-housing-codes/by-state/)

c. Properties must be free of illegal activities, including, but not limited to, the use, manufacturing, or sale of illegal substances; child or elderly abuse; or prostitution.
d. Properties must be accessible and capable of being used without unauthorized use of other private properties and provide means to escape in case of fire.
e. Each resident must be afforded adequate space to sleep and provide security for themselves and their belongings.
f. Properties must have natural or mechanical ventilation in every room or space and be free of pollutants that may threaten the health of residents.
g. Properties must have a water supply that is free from contaminants that may threaten the health of residents.
h. Properties must have adequate heating and cooling that are in proper operating condition.
i. Properties must have adequate natural or artificial lighting for indoor activities and to support the health and safety of the residents.
j. Properties must have sufficient electrical sources for essential appliances.
k. Properties must have an area for food preparation that includes suitable space and equipment to store, prepare, and serve food in a sanitary manner.
l. The property must have the appropriate trash removal or disposal accommodations.
m. Properties must have working plumbing with sanitary conditions maintained.
n. Properties must include battery-operated or hardwired smoke detectors outside each sleeping area, on each level, and are clearly audible. Smoke detectors may be single or multiple stations. Accommodations must be made for individuals with sensory impairments.

9. **Landlord** usually refers to the owner of real property, such as a house, building, or land that is leased or rented to another person or entity, called the tenant. In a lease contract, the landlord or landlady transfers part of his or her interest to the tenant. That is, the tenant can occupy and use the property.
10. **Mental Health Therapy** is visits to a mental health professional for conditions and may not be provided by a medical doctor (psychiatrist).

11. **Multiple Station Smoke Detectors** are all connected. If one detector is set off or tripped, all connected alarms will go off.
12. **Premises** are a building or complex in which a dwelling is located, including common areas and grounds.
13. **Property or Properties (unit)** is used to describe a dwelling that is rented to a tenant. Property includes apartment complexes, single-family homes, mobile homes, etc.
14. **Psychiatric Care** can include medical evaluations, care, and treatment by a psychiatric professional.
15. **Psychiatric Professionals** are individuals who are medical doctors with special training and education in mental health (psychiatrist).
16. **Rent Reasonableness Analysis** is used to determine if rents being charged to assisted properties are in line with market rents for unassisted properties.
17. **Single Station Smoke Detectors** operate individually and typically rely on 120 VAC and 9V batteries for power.
18. **Tenant** is a person who occupies land or property rented from a landlord.

Appendix C2

Outstate Acronyms

Acronym	Formal Term
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
ADLs	Activities of Daily Living
AIDS	Acquired Immune Deficiency Syndrome
CFR	Code of Federal Regulations
DES	Direct Enrollment Services
DHSS	Department of Health and Senior Services
EFA	Emergency Financial Assistance
FAA	Fire Administration Authorization
FAA Act	Fire Administration Authorization Act of 1992
FMR	Fair Market Rent
FPL	Federal Poverty Level
HAN	Housing Assistance Notification
HAV	Housing Assistance Verification
HICP	Health Insurance Continuation Program
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Person with AIDS
HUD	Department of Housing and Urban Development
ISP	Individual Service Plan
MHN	MO HealthNet
MO	Missouri
NEMT	Non-Emergency Medical Transportation
NFPA	National Fire Protection Association Standards
OMO	Outstate Missouri (Next Step funding)
PWD	People with Disabilities
QSM	Quality Service Manager
RW	Ryan White
STRMU	Short-Term Rent, Mortgage, and Utility
SWS	Statewide Services
TBRA	Tenant-Based Rental Assistance
VA	Veteran's Administration
VAWA	Violence Against Women Act

Appendix C3

Emergency Financial Assistance (EFA) Clipping

1. Date of EFA Request:
2. Reason for EFA Request:
3. What other payer sources are available to the client for assistance with payment of these services?
4. If available, why is the client not using these options?
5. What goals has the client identified to help prevent future requests for emergency assistance? Please list action steps regarding current and future goals to address income, budgeting, etc.
6. What is the payment due date for the EFA service request?

Appendix C4

Exception Request Narrative Clipping

Exception Request Narrative

Date exception was discussed with supervisor:

Total amount being requested (if applicable): $

If there is more than one entity that will be paid please break-down (if applicable).

AMOUNT: $ TO:

AMOUNT: $ TO:

AMOUNT: $ TO:

Indicate the service(s) being requested by placing an "X" in front of the service requested.

CORE SERVICES

Medical Case Management eligibility (Grantee approval only)

ADAP/Insurance Assistance

- Co-pay
- Premium
- Exemption from Mail Order Requirement
- Medications
- Other:

Outpatient/Ambulatory Medical Care

Mental Health Care

Substance Abuse Care

SUPPORT SERVICES

Housing Assistance

Utility Assistance

Deposit Assistance

Medical Transportation

Other:

*Please note – If any questions are not answered this request will be returned to the supervisor.

1. Provide specific details to explain/support this request.
2. What part of the services requested is outside the scope of the currently published policy?

3. What other payer sources (including MO HealthNet) have been reviewed or applied for to pay for this service in the past 12 months?

What date was the documentation scanned into SCOUT (if applicable)?:

4. If approved, how will the client manage this situation in the future without an exception request?

FOR OFFICE USE ONLY

Funding Source for the Exception Request:

Part A STL

Part A KC

Part B

ADAP

Appendix C5

Transportation ISP Clipping

1. Date of Request:
2. Does the client drive?
3. What other transportation options are available to the client?
4. If available, why is the client not using the other transportation options?
5. Why is the client requesting mileage reimbursement or a bus pass?

Appendix C6

Housing ISP Clipping

1. What steps have been identified to obtain and maintain stable housing? This must include current and future housing goals.
2. Explain the client's goals related to obtaining and/or maintaining current income or benefits.
3. What goals will the client set in order to obtain or maintain stable housing? Goals should be specific and may include finding employment that provides income to support housing costs, decreasing expenses, budgeting, finding low-cost housing, etc.
4. What goals has the client set to ensure that they will maintain treatment and care related to HIV/AIDS? This may include attending medical appointments, case management appointments, obtaining/maintaining health insurance, etc.
5. What other supportive services has the client identified as a need? (e.g., child support, independent living skills, family/social support networks, etc.)
6. What goals has the client set related to their supportive service needs?

Action(s) needed to meet need/goal (who, what, when)

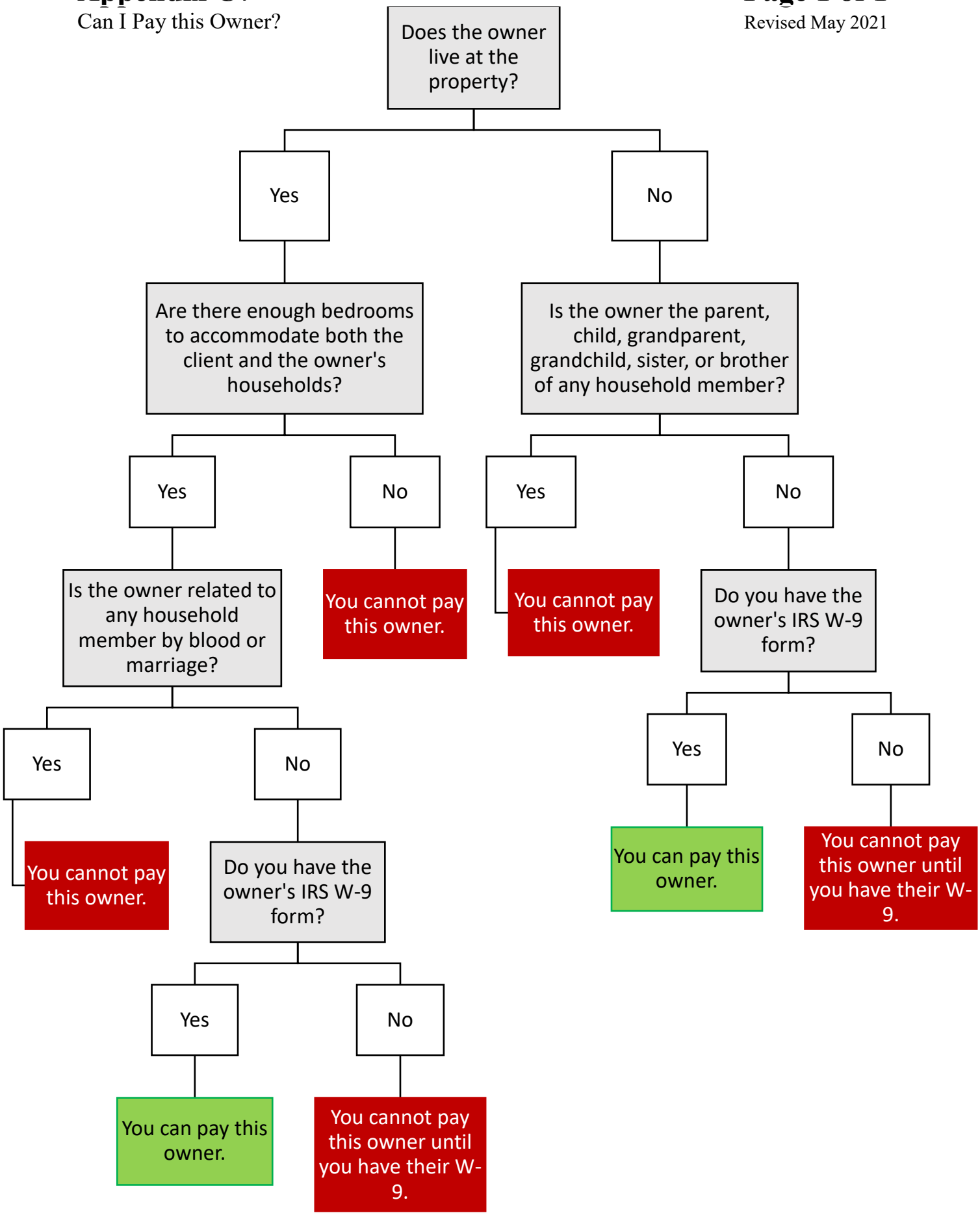
Appendix C7

Can I Pay this Owner Flowchart

Appendix C7

Can I Pay this Owner?

Revised May 2021



Appendix C8

Housing Program Fact Sheet

Housing Program Fact Sheet

Question: How does the Housing Program (HP) decide if my house or apartment qualifies for rental assistance?

Answer: The HP uses the Housing and Urban Development (HUD) Fair Market Rent (FMR) and Rent Reasonableness guidelines to determine if a client's rental property or potential rental property meets HUD standards. For more detail about the HUD Fair Market Rent and Rent Reasonableness standards please see 24 CFR 574.320 (a) at https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=24:3.1.1.3.7#se24.3.574_1320.

Question: How does the HP decide how much help I can get with my rent?

Answer: The HP uses the following considerations to determine the amount of money that can be paid toward your rent:

- Your income
- The number of people living, or planning to live in your home
- Whether those people are family members
- Whether other properties in the same area have similar rent amounts
- Your utility costs, if they are eligible for assistance

Note: If you are already living in a home, which has rent that is within HUD FMR and Rent Reasonableness guidelines, you may continue receiving assistance at the same rate as you currently get.

Question: What if my rent costs are more than what is allowed?

Answer: If your rent costs more than what is allowed to pay on your behalf, but you want to receive HP assistance:

- you must find another place to live; or
- you can talk to your landlord about lowering the rent to the allowable amount; or
- you can adjust your budget to pay the amount of rent that is over the allowable standards to your landlord.

If you are already in a lease with a rent cost that is over the allowable amount:

- you will be given until the end of the current lease term or 90-days to secure other housing; or
- you can talk to your landlord about lowering the rent to the allowable amount; or
- adjust your budget to pay the amount of rent that is over the allowable standards to your landlord.

If your lease automatically renews or goes to a month-to-month basis:

- you will be given 90-days to secure other housing; or
- you can talk to your landlord about lowering the rent to the allowable amount; or
- adjust your budget to pay the remaining amount of rent payable to the landlord.

Question: What if I can't find another place to live, get my landlord to lower rent, or pay the remaining amount of rent?

Answer: If you are having difficulties with any of those things, you may ask your Case Manager to request an extra 90-days of rent at the current rate to give you more time to make other living arrangements.

Question: Can I get help with my deposit?

Answer: Yes; however, housing deposit assistance is available to you one-time during your lifetime. Also, the maximum allowable amount for a housing deposit assistance cannot go over the cost of one month's rent.

Housing Program Fact Sheet

Question: What if I have to move because my rent is more than what is reasonable or more than other comparable rental property? Can I get help with the new deposit?

Answer: If you are in a current lease, which is over the allowable amount your Case Manager may submit an exception request on your behalf for the amount of the new deposit. However, the new property must also meet the allowable HUD expectations for FMR and rent reasonableness to qualify for deposit assistance.

Question: What if I only need assistance with my housing costs a few times during the year?

Answer: You may qualify for short-term assistance with housing or utility costs up to three times per program year (April 1st thru March 31st), if there are no other assistance programs available to you. Please speak to your Case Manager about requesting short-term assistance, if needed.

Question: What if I have an emergency and I have already used my three short-term requests?

Answer: You may qualify for emergency financial assistance (EFA) if the emergency requires immediate attention. Examples that qualify for assistance are danger of having your utilities shut-off, you are in danger of being evicted from your current rental location, or you need temporary emergency housing assistance. Keep in mind that EFA assistance is only available for a maximum of three times per program year (April 1st thru March 31st, and only if there are no other assistance programs available to you. Please speak to your Case Manager about requesting EFA, if needed.

Question: Which of my utilities can I get help with?

Answer:

The following expenses may be considered for assistance:	The following expenses will *not* be considered for assistance:
• electricity	• telephone
• fuel (e.g., natural gas, oil)	• internet
• water	• cable
• sewer	• additional expenses for appliances
• trash removal	• utilities which are separate from the rent paid to a landlord

Question: What if I already paid my bill but I found out I should have qualified for housing or utility assistance? Can I get reimbursed?

Answer: No. The HP cannot by law reimburse clients, or make direct payments to you for any housing or utility cost.

Question: Is there anything else I need to know about requesting housing related services?

Answer:

- You must apply for all other assistance programs before services will be approved by the Housing Program.
- You must correctly complete all required documentation and submit it to your Case Manager before your request for services will be reviewed, or approved.
- There is no guarantee that your request for services will be approved.
- You may ask your Case Manager for help with completing any of the housing program requirements.

Appendix C9

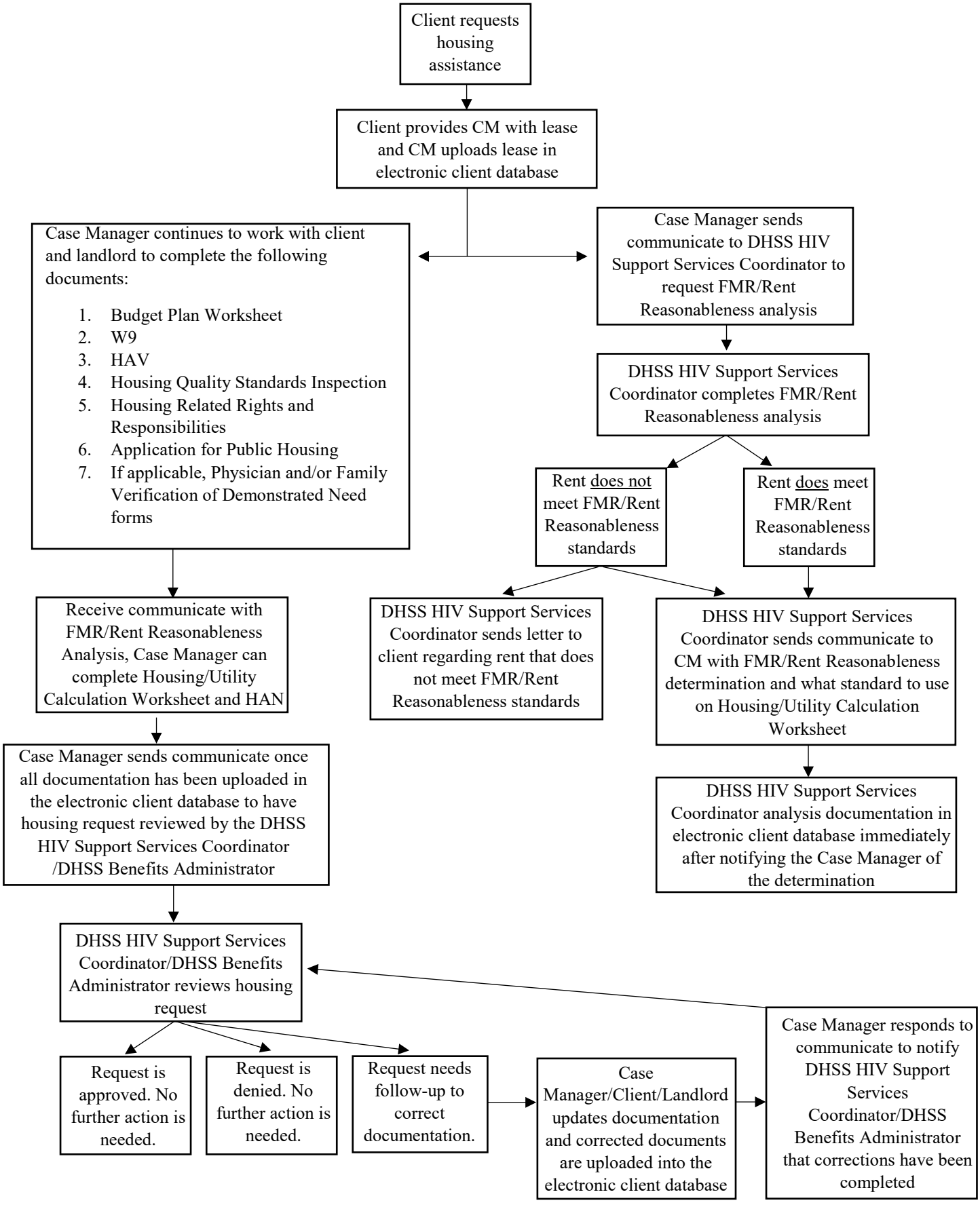
Outstate Service Referral Matrix

Outstate Services Referral Guide				
Program/Client Need	**Region**	**Referral Name**	**Service Description**	**Reference**
Outpatient Physician Visit (no insurance, no Medicaid, no Medicare)	Outstate/Part B (CE, NW, SE, SW)	HSI-Ambulatory/Outpatient Medical Care	Provides full payment for outpatient physician visits.	Outstate Services Manual Policy 5.1
Dental	Outstate/Part B (CE, NW, SE, SW)	HSI-Dental	Provides payment of up to $4,000 annually for dental services	Outstate Services Manual Policy 5.3
Deposit Assistance – Rental	Outstate/Part B (CE, NW, SE, SW)	HSI-Housing Srvs/RW/Deposit Services	Provides payment for rental deposits.	Outstate Services Manual Policy 7.2
Deposit Assistance – Utility	Outstate/Part B (CE, NW, SE, SW)	HSI – Utility Deposit	Provides payment for utility deposits.	Outstate Services Manual Policy 7.3
Emergency Financial Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Emer.Fin.Asst.-General/Other	Provides payment for some housing services, which require immediate payment.	Outstate Services Manual Policy 6.1
Exception Requests	Outstate/Part B (CE, NW, SE, SW)	Various – place under service referral for appropriate service type	Provides payment for some services that are outside of current established policies.	Outstate Services Manual Policy 6.2
TBRA Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Housing Srvs/HOPWA/Rental Subsidy	Provides payment for long-term housing assistance for clients in need of housing	Outstate Services Manual Policy 7.3
Mental Health Treatment	Outstate/Part B (CE, NW, SE, SW)	HSI-Mental Health Counseling	Provides payment for mental health services including office visits, evaluations, and payment for medications.	Outstate Services Manual Policy 5.4
Mortgage Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Housing Srvs/HOPWA/Mortgage Assistance	Provides payment for temporary assistance for mortgage payments (up to three times annually).	Outstate Services Manual Policy 7.4

Outpatient Substance Abuse Treatment	Outstate/Part B (CE, NW, SE, SW)	HSI-Substance Abuse Treatment Services	Provides payment for substance abuse services including office visits, evaluations, and payment for medications.	Outstate Services Manual Policy 5.5
STRMU Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Housing Srvs/RW/Rental Subsidy	Provides temporary payment assistance for rent (up to three times annually).	Outstate Services Manual Policy 7.4
Transportation	Outstate/Part B (CE, NW, SE, SW)	HSI-Transportation	Provides payment for medical transportation (up to $200.00 per month).	Outstate Services Manual Policy 6.3
Utility Assistance	Outstate/Part B (CE, NW, SE, SW)	HSI-Utilities	Provides short-term utility assistance (up to three times annually).	Outstate Services Manual Policy 7.4
Vision Services	Outstate/Part B (CE, NW, SE, SW)	HSI-Vision	Provides payment for vision services including one office visit and glasses frames and lenses.	Outstate Services Manual Policy 5.2

Appendix C10

Outstate Housing Request Flowchart


Client requests housing assistance
Client provides CM with lease and CM uploads lease in electronic client database
Case Manager continues to work with client and landlord to complete the following documents:
1. Budget Plan Worksheet
2. W9
3. HAV
4. Housing Quality Standards Inspection
5. Housing Related Rights and Responsibilities
6. Application for Public Housing
7. If applicable, Physician and/or Family Verification of Demonstrated Need forms
Case Manager sends communicate to DHSS HIV Support Services Coordinator to request FMR/Rent Reasonableness analysis
DHSS HIV Support Services Coordinator completes FMR/Rent Reasonableness analysis
Rent does not meet FMR/Rent Reasonableness standards
Rent does meet FMR/Rent Reasonableness standards
Receive communicate with FMR/Rent Reasonableness Analysis, Case Manager can complete Housing/Utility Calculation Worksheet and HAN
DHSS HIV Support Services Coordinator sends letter to client regarding rent that does not meet FMR/Rent Reasonableness standards
DHSS HIV Support Services Coordinator sends communicate to CM with FMR/Rent Reasonableness determination and what standard to use on Housing/Utility Calculation Worksheet
Case Manager sends communicate once all documentation has been uploaded in the electronic client database to have housing request reviewed by the DHSS HIV Support Services Coordinator /DHSS Benefits Administrator
DHSS HIV Support Services Coordinator analysis documentation in electronic client database immediately after notifying the Case Manager of the determination
DHSS HIV Support Services Coordinator/DHSS Benefits Administrator reviews housing request
Request is approved. No further action is needed.
Request is denied. No further action is needed.
Request needs follow-up to correct documentation.
Case Manager/Client/Landlord updates documentation and corrected documents are uploaded into the electronic client database
Case Manager responds to communicate to notify DHSS HIV Support Services Coordinator/DHSS Benefits Administrator that corrections have been completed