LOS ANGELES COUNTY
COMMISSION ON HIV

TEMPORARY HOUSING SERVICES

SERVICE STANDARDS FOR RYAN WHITE HIV/AIDS PROGRAM CARE AND TREATMENT SERVICES

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IMPORTANT: The service standards for Temporary Housing Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

Human Resource Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) # 16-02 (Revised 10/22/18): Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

HRSA HAB Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

Service Standards: Ryan White HIV/AIDS Programs

Introduction

Service standards outline the elements and expectations a Ryan White HIV/AIDS Program (RWHAP) provider follows when implementing a specific service category. The purpose of service standards is to ensure that all RWHAP providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP-funded agency or provider may offer in Los Angeles County.

Service description

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., medical health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referrals services, including assessment, search placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

HRSA program guidance

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

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

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

RWHAP funding may be used to pay for a RWHAP client's security deposit **if** a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not the RWHAP client. For more information, review the HRSA HAB Security Deposit program letter.

Eligibility and documentation requirements for RWHAP services in LA County

- Have a HIV-positive diagnosis
- Be a resident of Los Angeles County
- Have an income at or below 500% of the Federal Poverty Level
- Be uninsured or underinsured

- Given the barriers with attaining documentation for unstably housed People Living with HIV (PLWH), contractors are expected to follow the Los Angeles County Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms to verify eligibility for RWHAP services.

All contractors must meet the Universal Service Standards approved by the COH in addition to the following service standards.

Residential care facility for the chronically ill (RCFCI)

GENERAL REQUIREMENTS

RCFCI are licensed under the California Cord of Regulations, Title 22, Division 6, Chapter 8.5 to provide services in a non-institutional, home-like environment in any building or housing arrangement which is maintained and operated to provide 24-hour care and supervision to PLWH who are adults 18 years of age or older and are unable to work.

The goal of the RCFCI program is to improve the health status of PLWH who need to receive care, support, and supervision in a stable living environment to improve their health status. Clients receiving RCFCI services will have a maximum stay of 24 months. Approval will be required for extensions beyond 24 months based on the client's health status. Additional consultative services regarding housing, health benefits, financial planning, and referrals to other community or public resources may be offered.

Each RCFCI program must adhere to the following general requirements:

RCFCI GENERAL REQUIREMENTS	
STANDARD	MEASURE
RCFCIs are licensed to provide 24-hour care and supervision to any of the following: • Adults 18 years of age or older living with HIV/AIDS	Program review and monitoring to confirm.
RCFCIs may accept clients that meet each of the following criteria: • Proof of HIV diagnosis such as through verification in the local LA County data management system or a provider HIV diagnosis form. • Be certified by a qualified health care professional to need regular or ongoing assistance with Activities of Daily Living. • Have a Karnofsky score of 60 or less. • Have an unstable living situation. • Be a resident of Los Angeles County. • Have an income at or below 500% the Federal Poverty Level. • Cannot receive RWHAP services if other payor source is available for the same service.	Program review and monitoring to confirm.

RCFCIs may accept clients with chronic and life-threatening diagnoses requiring different levels of care, including: • Clients whose illness is intensifying and causing deterioration in their condition. • Clients whose conditions have deteriorated to a point where death is imminent. • Clients who have other medical conditions or needs or require the use of medical equipment that the facility can provide.	Program review and monitoring to confirm.
RCFCIs will **not** accept or retain clients who: • Require inpatient care. • Require treatment and/or observation for more than eight hours per day. • Have communicable tuberculosis (TB) or any reportable disease. • Require 24-hour intravenous therapy. • Have dangerous psychiatric conditions. • Have Stage II or greater decubitus ulcer. • Require renal dialysis in the facility. • Require life support systems. • Do not have chronic life-threatening illness. • Have a primary diagnosis of Alzheimer's disease. • Have a primary diagnosis of Parkinson's disease.	Program review and monitoring to confirm.
Maximum length of stay is 24 months with extensions based on client's health status.	Program review and monitoring to confirm.
RCFCIs will develop criteria and procedures to determine client eligibility to ensure that no other options for residential services are available.	Program review and monitoring to confirm.

INTAKE

As part of the intake process, the client file will include the following information, at minimum:

RCFCI INTAKE	
STANDARD	MEASURE
Eligibility for services determined.	Client files include documentation that eligibility requirements for RWHAP services is Los Angeles County are met.
Intake process is begun after completion of eligibility screening.	Intake tool is completed and included in client file.
Confidentiality Policy, Consent to Receive Services, and Release of Information forms are discussed and completed. Release of Information forms must be updated annually. New forms must be added for those individuals not listed on the	Release of Information form signed and dated by client on file and updated annually.

existing Release of Information; the form must specify what type of information can be released.	
Client is informed of Rights and Responsibilities and Grievance Procedures including the DHSP Customer Support Program.	Signed and dated forms in client file.

ASSESSMENT

Prior to acceptance of a client, the facility will obtain a written medical assessment of the client which enables the facility to determine if they are able to provide the necessary health-related services required by the client's medical condition. Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with Activities of Daily Living (ADLs). Upon reaching and sustaining a Karnofsky score above 70, RCFCI clients will be expected to transition towards independent living or to another type of services more suitable to their needs. Assessments will include the following:

RCFCI ASSESSMENT	
STANDARD	MEASURE
Written medical assessment completed or supervised by a licensed physician not more than three months old are required within 30 days of acceptance into RCFCI program.	Signed, dated medical assessment on file in client chart.
Assessments will include the following: • Need for palliative care • Age • Health status, including HIV and Sexually Transmitted Infection (STI) prevention needs • Record of medications and prescriptions • Ambulatory status • Family composition • Special housing needs • Level of independence • Level of resources available to solve problems • ADLs • Income • Benefits assistance/Public entitlements • Substance use and need for substance use services such as treatment, relapse prevention, and support groups • Mental health • Personal finance skills • History of evictions • Co-morbidity factors	Signed, dated assessment on file in client chart.

• Physical health care, including access to TB screening and routine and preventative health and dental care • Treatment adherence • Educational services, including assessment, General Education Diploma (GED), and school enrollment • Linkage to potential housing out-placements should they become appropriate alternatives for current clients (e.g., residential treatment facilities and hospitals) • Representative payee • Legal assistance and advocacy	
Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADLs.	Record of assessment on file in client chart.
If a RCFCI cannot meet a client's needs, a referral must be made to an appropriate health facility.	Documentation of client education on file in client chart.
Upon intake facility staff provide or link client with the following: • Information about the facility and its services • Policies and procedures • Confidentiality • Safety issues • House rules and activities • Client rights and responsibilities • Grievance procedures • Licit and illicit drug interactions • Medical complications of substance use hepatitis • Important health and self-care practices and information about referral agencies that are supportive of PLWH	Documentation of client education on file in client chart.

INDIVIDUAL SERVICES PLAN (ISP)

RCFCIs will ensure that there is an ISP for each client. A service plan must be developed for all clients within 7 days of admissions to RCFCI program. The plan will serve as the framework for the type and duration of services provided during the client's stay in the facility and should include the plan review and reevaluation schedule. RCFCI staff will regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan will be updated every three months or more frequently as the client's condition warrants. The plan will also document mechanisms to offer or refer clients to primary medical services and case management services as appropriate. The plan should be developed with the client and should include the following:

RCFCI INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	MEASURE
ISP will be completed within 7 days of admission to RCFCI program.	Needs and services plan on file in client chart.
The ISP will include, at minimum: • Current health status • Current mental health status • Current functional limitations and abilities • Current medications • Medical treatment/therapy • Specific services needed • Intermittent home health care required • Agencies or persons assigned to carry out services • "Do Not Resuscitate" order, if applicable	Needs and services plan on file in client chart.
Plans should be updated every 3 months or more frequently to document changes in client's physical, mental, emotional, and social functioning.	Updated needs and services plan on file in client chart.
Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADLs.	Record of reassessment on file in client chart.
If a client's needs cannot be met by a facility, the facility will assist in relocating the client to the appropriate level of care.	Record of relocation activities on file in client chart.
RCFCIs will ensure each client's ISP is developed the ISP team. In addition to the Registered Nurse (RN) case manager, the following persons will constitute the ISP team and will be involved in the development and updated of the client's ISP: • Client and/or their authorized representative • Client's physician • Facility house manager • Direct care personnel • Facility administration/designee • Social worker/placement worker • Pharmacists, if needed • Others, as deemed necessary	Record of ISP team on file in client chart.

MONTHLY CASE CONFERENCE

A monthly case conference will include review of the ISP, including the client's health and housing status, the need for and use of medical and other support services, and progress towards discharge, as appropriate.

RCFCI MONTHLY CASE CONFERENCE	
STANDARD	MEASURE
Attendees at the monthly case conference will include, at minimum: • Client • RN • Case manager • Direct care staff representatives Participants can include the following, as approved by client: • Housing coordination staff and/or representatives from other community organizations • Client advocate, family members, or another representative	Documentation of case conference on file in client chart including outcomes, participants, and necessary steps to obtain services and support for the client.

SERVICE AGREEMENTS

RCFCIs will obtain and maintain written agreements or contracts with the following:

RCFCI SERVICE AGREEMENTS	
STANDARD	MEASURE

RCFCIs will obtain and maintain written agreements or contracts with:
• A waste disposal company registered by the California Department of Toxic Substance Control and the California Department of Public Health, if generating or handling bio-hazardous waste.
• A licensed home health care or hospice agency and individuals or agencies that can provide the following basic services:
  ○ Case management services
  ○ Counseling regarding HIV/AIDS, including current information on treatment and its possible effects on the client's physical and mental health
  ○ Counseling on death, dying, and the grieving process; psychosocial support services; substance use counseling
  ○ Nutritionist services
  ○ Consultation on housing, health benefits, financial planning, and availability of other community-based and public resources, if
	Written agreements on file at RCFCI agency.

these services are not provided by RCFCI staff or subcontracted home health agency personnel	

MEDICATION MANAGEMENT

Administration of medication will only be performed by an appropriate skilled professional.

RCFCI MEDICATION MANAGEMENT	
STANDARD	MEASURE
Direct staff will assist client with self-administration medications if the following conditions are met: • Have knowledge of medications and possible side effects • On-the-job training in the RCFCI's medication practices	Record of conditions on file at provider agency.
The following will apply to medication which are centrally stored: • Medications must be kept in a locked place that is not accessible to persons other than staff who are responsible for the supervision of the centrally stored medications. • Keys used for medications must not be accessible to clients. • All medications must be labeled and maintained in compliance with label instructions and state and federal laws.	Record of conditions on file at provider agency.

SUPPORT SERVICES

RCFCI SUPPORT SERVICES	
STANDARD	MEASURE
Programs will provide or coordinate the following, at minimum: • Provision and oversight of personal and supportive services • Health-related services • Transmission risk assessment and prevention counseling • Social services • Recreational activities • Meals • Housekeeping and laundry • Transportation • Provision and/or coordination of all services identified in the ISP	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

• Assistance with taking medication • Central storing and/or distribution of medications • arrangement of and assistance with medical and dental care • Maintenance of house rules for the protection of residents • Arrangement and managing of resident schedules and activities • Maintenance and/or management of resident cash resources or property	

EMERGENCY MEDICAL TREATMENT

RCFCI EMERGENCY MEDICAL TREATMENT	
STANDARD	MEASURE
Clients requiring emergency medical treatment for physical illness or injury will be transported to an appropriate medical facility.	Program review and monitoring to confirm.

DISCHARGE PLANNING

Discharge planning should start as soon as the client achieves stability and readiness towards alternative forms of housing. As much as possible, early planning (at least 12 months prior to the end date of the client's term in the RCFCI program) must be conducted to ensure a smooth transition/discharge process. A Discharge/Transfer Summary will be completed by the RN case manager or the social worker for all clients discharged from the agency.

RCFCI DISCHARGE PLANNING	
STANDARD	MEASURE
RCFCIs provide discharge planning services that include, at minimum: • Linkage to primary medical care, emergency assistance, supportive services and early intervention services, as appropriate • Linkage to supportive services that enhance retention in care (e.g., case management, melas, nutritional support, and transportation) • Linkage to housing services including permanent housing, independent housing, supportive housing, long-term assisted living, or other appropriate housing	Discharge plan on file in client chart.
A Discharge/Transfer Summary will be completed for all clients discharged from the RCFCI. The summary will include, at minimum:	Discharge/Transfer Summary on file in client chart.

• Admission and discharge dates • Services provided • Diagnosis(es) • Status upon discharge • Notification date of discharge • Reason for discharge • Transfer information, as applicable	

PROGRAM RECORDS

Programs will maintain separate, completed, and current records for each client in sufficient detail to permit an evaluation of services. These notations will be dated and include, at minimum, type of service provided, clients response, if applicable, and signature and title of person providing the service.

RCFCI PROGRAM RECORDS	
STANDARD	MEASURE
Client records on file at provider agency that include, at minimum: • Client demographic data • Admission agreement • Names, addresses, and telephone numbers of physician, case manager, and other medical and mental health providers • Names, addresses, and telephone numbers of any person or agency responsible for the care of the client • Medical assessment • Documentation of HIV diagnosis • Written certification that each family unit member is free from active TB • Copy of current childcare contingency plan, if applicable • Current ISP • Record of ISP contacts • Documentation of all services provided • Record of current medications • Physical and mental health observations and assessments	RCFCIs will maintain sufficient records on each client.

LINKAGE TO MEDICAL CARE COORDINATION (MCC) AND BENEFITS SPECIALTY SERVICES (BSS)

Based on assessment and client needs, eligible individuals should be linked to RWHAP-funded MCC services and BSS. MCC service providers must follow DHSP's MCC protocol. For MCC specific service standards, click HERE. For BSS specific service standards, click HERE.

Transitional residential care facility (up to 24 months)

GENERAL REQUIREMENTS

A Transitional Residential Care Facility (TRCF) provides short-term housing with ongoing supervision and assistance with independent living skills for PLHW who are homeless or unstably housed. TRCFs are 24-hour alcohol and drug-free facilities that are secure and home-like.

The goal of the TRCF program is to help clients be safely housed while they find a more permanent, stable housing situation. This service focused on removing housing-related barriers that negatively impact a client's ability to access and/or maintain HIV care or treatment.

TRCFs must maintain a current, written, definitive plan of operation that includes, at minimum:

- Admission/discharge policies and procedures
- Admission/discharge agreements, including policies and procedures regarding alcohol and/or drug use on-site and off-site
- Provide ample opportunity for family participation in activities in the facility
- Include a safety plan with precautions enacted to protect clients and staff, as appropriate (e.g., for facilities that admit or specialize in care for clients who have a propensity for behaviors that results in harm to self or others)
- Adhere to basic facility safety requirements under federal laws and state of California health and safety codes

TRCF GENERAL REQUIREMENTS	
STANDARD	MEASURE
TRCFs are short-term housing accommodations providing supervision and supportive services to adults 18 years of age or older living with HIV.	Program review and monitoring to confirm.
TRCFs may accept clients that meet each of the following criteria: • Proof of HIV diagnosis such as through verification in the local LA County data management system or a provider HIV diagnosis form • Have a Karnofsky score of 70 or above; able to work, volunteer, and if receiving Supplemental Security Income, able to enroll into ticket-to-work program • Homeless or unstably housed • Be a resident of Los Angeles County • Have an income at or below 500% the Federal Poverty Level • Cannot receive RWHAP services if other payor source is available for the same service	Program review and monitoring to confirm.
TRCFs will not accept or retain clients who: • Require daily assistance with ADLs • Are currently engaging in alcohol or drug use	Program review and monitoring to confirm.

• Require direct supervision due to physical or mental health diagnoses	
Maximum length of stay is 24 months with extensions considered on an as needed basis based on client needs and progress of documented goals.	Program review and monitoring to confirm.
TRCFs will develop criteria and procedures to determine client eligibility to ensure that no other options for residential services are available.	Program review and monitoring to confirm.

INTAKE

As part of the intake process, the client file will include the following information, at minimum:

TRCF INTAKE	
STANDARD	MEASURE
Eligibility for services is determined.	Client files include documentation that eligibility requirements for RWHAP services in LA County are met.
Intake process is begun after the interview process is completed and acceptance into TRCF has been determined.	Intake tool is completed and in client file.
Confidentiality Policy, Consent to Receive Services, and Release of Information forms are discussed and completed. Release of Information forms must be updated annually. New forms must be added for those individuals not listed on the existing Release of Information; the form must specify what type of information can be released.	Release of Information form signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibilities, and Grievance Procedures, including the DHSP Customer Support Program.	Signed and dated forms in client file.

ASSESSMENT

At minimum, each client will be assessed to identify strengths and gaps in their support system to transition move toward independent living, permanent housing, or another type of residential services more suitable to their needs. permanent housing.

TRCF ASSESSMENT	
STANDARD	MEASURE
Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs	Signed, dated assessment on file in client chart.

• Income • Public entitlements • Current engagement in medical care • Substance use history; if applicable, current recovery program status, relapse prevention or additional support needs • Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • For clients with substance use disorders, case managers must assess eligibility and readiness for residential substance use treatment facilities • Eligibility for MCC services • Physical health care, including access to TB screening, and routine and preventative health and dental care • Treatment adherence • Educational services, including assessment, GED, and school enrollment • Linkage to potential housing placements, as they become available	
Clients receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with independent living skills.	Signed, dated assessment on file in client chart.
Upon intake, facility staff must provide client with the following: • Admission agreement, including information about the facility and its services • Policies and procedures • Confidentiality • House rules • Client rights and responsibilities • Grievance procedures • Program requirements and expectations	Signed, dated documentation maintained in client chart.

INDIVIDUAL SERVICE PLAN (ISP)

TRCFs will ensure that an ISP is created jointly with each client and includes action steps to ensure linkage and retention in HIV medical care. Based upon the initial assessment, the ISP will be completed within 7

days of the client's admission. The ISP will address the short-term and long-term housing needs of the client and identify resources for housing and referrals to appropriate medical and social services.

TRCF INDIVIDUAL SERVICE PLAN	
STANDARD	MEASURE
ISP will be completed within 7 days of the client's admission.	ISP on file in client chart, signed by client and TRCF staff and updated every 3 months or as needed based on client's individual needs.
ISP will include, at minimum: • Current health status and treatment adherence • Current mental health status and treatment adherence, if applicable • Current employment status or outlined goal to obtain employment • Current education status or vocational training, if applicable • Budgeting goals and/or status of current budget plan • Housing goals, including action steps • Status of any legal issues and steps being taken to resolve them	ISP on file in client chart signed by client and TRCF staff.
If a client's needs cannot be met by TRCF, the facility will assist in relocating the client to appropriate level of care. This may include possible placement in RCFCI program or substance use treatment facilities.	Record of relocation activities on file in client chart.
TRCFs will ensure that each client's ISP is developed by the ISP team. In addition to the facility management and the master's level social worker (MSW), the following persons will constitute the ISP team and will be involved in the development and updating of the client's ISP: • Client and/or authorized representative • Physical health care providers, if applicable • Mental health care providers, if applicable • Social worker/case manager, if applicable • Others, as deemed necessary	ISP on file in client chart, signed by client, TRCF staff and any additional participants involved in developing ISP.

MONTHLY CARE CONFERENCE

A monthly case conference will include review of the ISP, including the client's health and housing status, the need for and use of medical and other support services, and progress towards discharge as appropriate.

TRCF monthly case conference	
STANDARD	MEASURE

Attendees at the monthly case conference will include, at minimum: • Client • Facility management staff • Social worker Participants can include the following, as approved by the client: • Housing coordination staff and/or representatives from other community organizations • Client advocate, family member(s), or another representative Monthly case conference includes, at minimum: • Status of current goals • Status of physical and/or mental health • Status of employment and/or education or vocational training • Progress towards discharge	Documentation of case conferences on file in client chart, including outcomes, participants, and necessary steps to obtain services and support for the client.

MEDICATION STORAGE

Each client is responsible to obtain their medications, keep them stored in the locked area provided to each client, and take their medication as prescribed.

TRCF MEDICATION STORAGE	
STANDARD	MEASURE
TRCFs will keep an updated list of current medications.	Record of medication list to be kept in client file.

SUPPORT SERVICES

TRCF SUPPORT SERVICES	
STANDARD	MEASURE
TRCFs will provide or coordinate the following, at minimum: • Health-related services • Mental-health related services • Transmission risk assessment and prevention counseling • Social services • Maintenance of house rules for the protection of clients • Budget planning • Discharge planning • Assistance with completion of application process for any housing program	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

Emergency medical treatment

TRCF EMERGENCY MEDICAL TREATMENT	
STANDARD	MEASURE
Clients requiring emergency medical treatment for physical illness or injury will be transported to appropriate medical facility.	Program review and monitoring to confirm.

DISCHARGE PLANNING

Discharge planning and goals should start within 30 days of admission. Discharge/Transfer Summary will be completed by facility management staff ad the social worker for all clients discharged from the agency.

TRCF DISCHARGE PLANNING	
STANDARD	MEASURE
Discharge planning services include, at minimum: • Linkage to primary medical care, emergency assistance, supportive services, and early intervention services, as appropriate • Linkage to supportive services that enhance retention in care (e.g. case management, meals, nutritional support, and transportation) • Linkage to housing services including permanent housing, independent housing, supportive housing, long-term assisted living, or other appropriate housing	Discharge plan on file in client chart.
A Discharge/Transfer Summary will be completed for all clients discharge from the agency. The summary will include, at minimum: • Admission and discharge dates • Services provided • Diagnoses • Status upon discharge • Notification date of discharge • Reason for discharge • Transfer information, as applicable	Discharge/Transfer Summary on file in client chart.

PROGRAM RECORDS

Programs will maintain separate, complete, and current records for each client in sufficient detail to permit an evaluation of services. These notations will be dated and include, at minimum, type of service(s) provided, client's response, if applicable, and signature and title of the person providing the service.

TRCF PROGRAM RECORDS	
STANDARD	MEASURE
Client record on file at provider agency that includes, at minimum:	Programs will maintain sufficient records on each client.

• Client demographic data • Admission agreement • Names, addresses and telephone numbers of physician, case manager and other medical and mental health providers • Documentation of HIV diagnosis • Written certification that client is free from active TB • Current ISP • Record of ISP contacts • Documentation of all services provided • Record of current medications • Physical and mental health observations	

LINKAGE TO MEDICAL CARE COORDINATION (MCC) AND BENEFITS SPECIALTY SERVICES (BSS)
Based on assessment and client needs, eligible individuals should be linked to RWHAP-funded MCC services and BSS. MCC service providers must follow DHSP's MCC protocol. For MCC specific service standards, click HERE. For BSS specific service standards, click HERE.

Transitional housing (up to 24 months)

Transition housing (TH) is designed to provide PLWH and their families who are homeless or unstably housed with the interim stability and support to successfully move to and maintain permanent housing. TH may be used to cover the costs of up to 24 months of housing with accompanying supportive services. TH pertains to short-term rentals, short-term residential and transitional programs designed to stabilize an individual and to support transition to a long-term sustainable housing situation.

INTAKE
As part of the intake process, the client file will include the following information, at minimum:

TRANSITIONAL HOUSING INTAKE	
STANDARD	MEASURE
Eligibility for services is determined	Client files include documentation that eligibility requirements for RWHAP services in Los Angeles County are met.
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.
Confidentiality Policy, Consent to Receive Services, and Release of Information forms are discussed and completed. Release of Information forms must be updated annually. New forms must be added for those individuals not listed on the existing Release of Information; the form must specify what type of information can be released.	Release of Information form signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibilities and Grievance Procedures.	Signed and dated forms in client file.

Clients will complete additional documentation as appropriate to comply with funding agency requirements.	Signed and dated forms in client file.

ASSESSMENT

At minimum, each prospective client will be assessed to identify strengths and gaps in their support system to move toward longer term or permanent housing.

TRANSITIONAL HOUSING ASSESSMENT	
STANDARD	MEASURE
Clients or representatives will be interviewed to complete eligibility determination, assessment and participant education.	Record of eligibility, assessment and education on file in client chart.
Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in medical care • Substance use history • Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • For clients with substance use disorders, case managers must assess eligibility and readiness for residential substance use treatment facilities • Eligibility for MCC services	Signed, dated assessment on file in client chart.

HOUSING CASE MANAGEMENT WITH HOUSING PLAN

TRANSITIONAL HOUSING PLAN	
STANDARD	MEASURE
Housing plan will include the following: • Describe specific action and target dates for securing additional services (as needed) and pathway to stable and permanent housing.	Housing plan on file in client chart.

• Evidence of service referrals and completion of medical and supportive services for the client. • Evidence and dates of changes made to the housing plan. • Reviewed with the client monthly to ensure that services and timeliness are met to achieve the goal of transitioning the client to stable and permanent housing.	

LINKAGE TO MEDICAL CARE COORDINATION (MCC) AND BENEFITS SPECIALTY SERVICES (BSS)
Based on assessment and client needs, eligible individuals should be linked to RWHAP-funded MCC services and BSS. MCC service providers must follow DHSP's MCC protocol. For MCC specific service standards, click HERE. For BSS specific service standards, click HERE.

Emergency/crisis housing assistance

Emergency/crisis housing assistance may by provided through hotel/motel vouchers and/or placements in emergency shelters. Emergency housing pertains to emergency stays intended to assist clients with immediate housing crises.

Short-term facilities provide temporary shelter to eligible individuals to prevent homelessness and allow an opportunity to develop an Individual Housing and Service Plan to guide client linkage to permanent housing. Hotel/motel vouchers and emergency shelters are available for a maximum of 60 days per year. Agencies must provide meal vouchers and/or grocery gift cards to ensure that clients have access to food during their stay in motels/hotels or emergency shelters. Eligible clients may receive dup to 3 meals per day. Emergency/crisis housing assistance providers much adhere to the following requirements:

EMERGENCY/CRISIS HOUSING CASE MANAGEMENT REQUIREMENTS	
STANDARD	MEASURE
To access emergency/crisis housing assistance, a client must be receiving case management services from a RWHAP-funded agency. Case management services will ensure that the client: • Is engaged in care. • Has a definitive housing plan that assess their housing needs and assist them in obtaining longer term housing withing the 60-day limit (residential substance use or mental health treatment program, RCFCI, transitional housing, or permanent housing). • Is receiving supportive services that promote stabilization, including needs assessments, case management, mental health counseling and treatment, substance use counseling and treatment,	Program review and monitoring to confirm.

benefits counseling, assistance in locating and obtaining affordable housing and follow-up services. • Case managers should attempt to secure other types of housing prior to exhausting a client's emergency voucher limit. • Under extenuating circumstances, a client may receive more than 60 days of hotel/motel, emergency shelter, and meal vouches under this program (e.g., a client is on a waiting list for a housing program with a designated move-in date that extends past the 60-day period). Such extensions are made on a case-by-case basis and must be carefully verified.	

REQUIRED DOCUMENTATION

Case managers are responsible for working with clients to secure necessary documents such as:

EMERGENCY/CRISIS HOUSING REQUIRED DOCUMENTATION	
STANDARD	MEASURE
Client intake form	Signed by both client and case manager, on file in client chart.
Case Management Housing Plan and Consent to Release Information	Signed by client, on file in client chart.
Rules and regulations reviewed by case manager	Signed by both client and case manager, on file in client chart.
HIV diagnosis form	Program review and monitoring to confirm.
Other documentation required by agencies to comply with funding agency requirements.	Agency records and client files.
Housing plan that describes specific action and target dates for securing additional services (as needed) and pathway to transitional and/or permanent housing.	Housing plan on file in client chart.
Self-attestation forms or documents already secured under other RWHAP-funded agencies may be used to avoid duplication and ease administrative burden on the client and service providers.	Self-attestation forms on file in client chart.

LINKAGE TO MEDICAL CARE COORDINATION (MCC) AND BENEFITS SPECIALTY SERVICES (BSS)

Based on assessment and client needs, eligible individuals should be linked to RWHAP-funded MCC services and BSS. MCC service providers must follow DHSP's MCC protocol. For MCC specific service standards, click HERE. For BSS specific service standards, click HERE.