Human Resources Administration
Department of
Social Services

TESTIMONY

"Oversight: Recent Policy Changes at HASA"

New York City Council General Welfare Committee

February 8th, 2012

Good afternoon Chairwoman Palma and members of the General Welfare Committee. My name is Jacqueline Dudley, I'm the Deputy Commissioner for the HIV/AIDS Services Administration (HASA) part of the Human Resources Administration (HRA). With me here today is Dr. Frank Lipton, Executive Deputy Commissioner of HRA's Customized Assistance Services (CAS). As you are aware, HASA has recently implemented several policies that both increase our efficiency and ensure the long-term wellness and self-sufficiency of our clients. However, before reviewing these policies I would like to provide you with a short update on the HASA program as a whole.

HASA provides high quality services that are individualized, efficient, and effective. Our work brings all sectors of the community together to ensure that medically-eligible individuals and their families have adequate housing, financial security, medical care and other needed services. As the most comprehensive program of its kind in the country, HASA currently serves over 32,000 medically eligible clients and their families totaling over 46,000 individuals. In order to adapt to the evolving needs of HASA clients we have developed a number of initiatives, a few of which I would like to highlight.

To better facilitate the relocation of homeless single adults and families residing in emergency housing into stable homes, we developed a Housing Placement Unit (HPU) that has now been in operation for four years. Working in coordination with community based organizations, many of which offer substance abuse and/or mental health treatment programs, HPU has relocated over 500 of the hardest to serve long term residents out of our emergency single room occupancy (SRO) housing population. This has helped bring HASA's SRO census under 800 for the first time in many years. In addition, we have also revised our homeless diversion assessment tools in order to provide clients additional alternatives to emergency housing. This assessment tool provides an opportunity to not only strengthen the screening process for emergency housing placement, but ensures that clients formulate an exit strategy into permanent housing.

HPU case managers also serve as Private Market Housing Liaisons within our Housing Services Unit whose focus is on linking clients to private market housing. Over the past years, these liaisons have connected clients to brokers, realtors and landlords, resulting in hundreds of apartments being leased. In addition, apartment vacancies offered by landlords and real estate agents are uploaded into HASA Web, our electronic case management program, and shared

with clients in need of assistance with apartment searches. We believe that these mechanisms have greatly assisted in locating housing options for our clients.

However, we understand the Committee has some questions about several more recent changes. Two of these changes have been implemented successfully throughout the agency. As part of HRA's January 2011 Program to Eliminate the Gap (PEG), fees paid to brokers to secure apartments for cash assistance recipients were reduced from one month's rent to half a month's rent with a savings of 8 million in City Tax Levy (CTL) dollars. This policy is applicable to all broker fees paid by HRA and not only to HASA clients. HASA has not seen a reduction in the number of requests to approve new apartments since the new broker fee policy went into effect. Many of the brokers who have experience assisting HASA clients in finding apartments have continued to do so after implementation of the new plan.

In fact, for the period preceding this policy change, from March through December 2010, the HASA program approved 3,595 new private market apartments. Subsequent to the implementation of this policy, during the same months in 2011, 3,731 requests were approved for new apartments which amounts to an increase of nearly 4 percent. Additionally, not only has HASA's SRO population continued to decrease, but emergency housing occupancy dropped from 935 to 774 between December 2010 and December 2011. This has been accomplished through a shared network of landlords and brokers within and across the boroughs. This list is also offered to contracted housing providers who need additional housing leads for their clients.

In addition, to better utilize limited government dollars, HRA changed the process of providing cash security deposits when clients identify new housing to a voucher system. For City Fiscal Year (CFY) 2011 there has been a significant decline in the number of security deposits paid, from an average of $2.5 million per month when we issued cash to under $100 thousand per month in voucher redemptions. Millions of dollars of government funds were unnecessarily being held as deposits across the City, with most never being returned to the agency. Landlords are still guaranteed a security payment by simply providing certification of either non-payment of rent or damages after the client leaves. It is estimated that this change will save the city over $6 million a year.

As I mentioned earlier, the needs of HASA clients continue to evolve since the program began in the 1980s. Recent medical advances in the field of HIV/AIDS treatments have thankfully

improved our average client's quality of life and expected lifespan while shifting their service needs from short-term crisis intervention actions to long-term wellness and self-sufficiency goals and activities.

For some HASA clients, one of the largest barriers to meeting these long-term goals is substance abuse. Substance abuse results in diminished health outcomes, increased noncompliance with HIV treatments, and more risk taking behaviors that increase the likelihood of HIV transmission. According to a NYC Department of Health and Mental Hygiene report issued in June 2010, there is a strong link between substance abuse and high risk behaviors that results in new HIV/AIDS cases in the City. Additionally, as noted by the National Institute on Drug Abuse requiring individuals to go for substance abuse treatment can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions. For these reasons we have increased our focus on substance abuse screening and assessment, treatment referral, enrollment and compliance for HASA clients.

In New York State, as a condition of ongoing cash assistance (CA) eligibility, clients who are determined by a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) to need treatment are mandated to participate in treatment which is part of a long-term self sufficiency plan. Non-compliance for a non-HASA client typically results in durational sanctions pursuant to New York Social Services Law and regulation. However, HRA has determined an alternative approach for HASA clients who fail to comply. For HASA clients, we worked collaboratively with Dr. Lipton and his staff at CAS to develop a substance abuse initiative that placed CASAC staff on-site at all twelve HASA offices, this initiative began in 2003. Compliance with treatment referrals for our CA clients has been much higher than for our HASA clients. In the last quarter of 2011, 7,981 CA clients were referred for substance abuse treatment and 6,302 complied while in the same period 939 HASA clients were referred for treatment and 450 complied. Through this program, our goal is to achieve improved substance abuse treatment compliance for our HASA clients.

Even prior to the implementation of this new policy, pursuant to State regulations all applicants for cash assistance including HASA clients were subject to screening for substance abuse. However, screenings may also occur if clients request frequent grants for rent and/or utility arrears, emergency housing placements or multiple Client Benefit Identification Cards card replacements. If the CASAC determines the client is in need of substance abuse treatment,

they are encouraged to comply with the treatment process. Clients must report to their treatment program as scheduled and participate in the activities delineated in their treatment plan. It is imperative that I make clear that at no point in this process, is a HASA client or applicant denied shelter due to substance abuse or because of failure to comply with the CASAC treatment referrals and recommendations.

A client's failure to participate in substance abuse treatment after referral by a CASAC will be one of the factors considered when HASA reviews an application for Case by Case Financial Assistance. HASA clients whose request for rent arrears or a new apartment is declined for failure to comply will be offered supportive housing placement. HASA clients who choose supportive housing will have access to on-site supportive services including linkages to substance abuse treatment. The substance abuse treatment initiative is one of the many demonstrations of our commitment to the well being of those we serve.

Before I conclude, it is important that I point out that HASA's substance abuse treatment policy minimizes high risk behavior by those with HIV/AIDS decreasing the number of new infections while improving the health of our current clients. In meeting the evolving needs of HASA clients, this policy is a rational and needed approach to ending the cycle of substance abuse affecting our clients today.

STATEMENT TO THE HEALTH COMMITTEE OF THE COUNCIL OF THE CITY OF NEW YORK
February 8, 2012

TESTIMONY FOR HEARING ON HASA POLICY CHANGES

My name is Dorella Walters, and I am the Community Co-Chair of the HIV Health and Human Services Planning Council of New York (Planning Council). Thank you for the opportunity to present to you today. The Planning Council is charged with setting priorities for and allocating $121 million in federal funding from the Health Resources and Services Administration (HRSA) for treatment and care services for People Living with HIV/AIDS (PLWHA). Treatment and care includes both medical and social support services such as housing. As a result of the concerns of the Planning Council, I am presenting this testimony on the negative impact of three recent policy changes at New York City's HIV/AIDS Services Administration on PLWHAs' ability to locate and remain in housing. My comments do not necessarily reflect the opinion of the Department of Health & Mental Hygiene or the Office of the Mayor.

In February and March 2011, the NYC Human Resources Administration (HRA) changed its long-standing policies regarding payment of brokers' fees and security deposits on behalf of extremely poor New Yorkers who are eligible for a housing allowance as part of their household's public assistance budget.

Brokers' Fees:

HRA advances security deposits and pays broker's fees in order to enable eligible persons to use State and City funded rental subsidies to secure apartments in the expensive and highly competitive New York City private rental market. Rental assistance and other housing supports for poor New Yorkers living with AIDS or other advanced HIV related illness are administered by HRA's HIV/AIDS Services Administration (HASA). HRA/HASA will no longer provide cash security deposits to enable clients to secure apartments. HASA now only pays half of a broker's fees, which are now limited to an amount equal to half of one month's rent (a 50% reduction from prior policy). Since HASA now only pays half of a broker's fee for finding housing, HASA clients are expected to find the other half of the broker's fee. HASA clients are often

destitute with extremely limited job skills and are unable to earn the money to pay the fee. Reports have surfaced of clients returning to sex work and selling drugs and hawking their HIV medications in order to obtain the money.

Security Deposit:

- HASA is no longer providing security deposits to landlords on behalf of clients. Instead, HASA is issuing vouchers to the landlords. If a client damages a room or apartment, the landlord can use the voucher to request compensation for damages. Without the security deposit, many landlords are no longer willing to rent to HASA clients.

Drug Screening:

- HASA clients with drug problems are required to engage in treatment for substance use. Some, however, choose not to participate. PLWHAs who decide not to seek treatment will have a choice of supportive housing or may no longer be able to obtain the allotted "enhanced rental assistance" or may not receive rent arrears money once in compliance. These restrictions are operative until the client can provide proof that he or she is actively engaged in substance use treatment. At this time, there is no clear indication how HASA clients with drug problems would specifically be selected since there is no screening process that has been confirmed. Also, these new guidelines would be prohibitive and increase the likelihood that PLWHA's would lose access to their housing.

Out of the $121 million grant from HRSA, $11 million goes to agencies providing housing services. According to the master contractor charged with handling the money, Public Health Solutions, HASA policies are having a distinct impact on the agencies we fund. Contractors have lost brokers and landlords, meaning that staff has to work harder to place clients. Additional staff effort has focused on establishing new relationships with brokers and landlords who are willing to work within the new HASA regulations.

Public Health Solutions provided increases to contractor reimbursement rates to account for the additional staff effort as well as to recognize the increased cost of running programs over time. Public Health Solutions also adjusted service goals to reflect actual performance history. With the increased rates and service adjustments, contractors were able to maintain their staffing and meet projected service goals. The net impact of the HASA changes was increased contractor effort to place clients and an additional cost to the Ryan White portfolio from the increase to contract amounts.

As you consider your budget priorities, we implore you to encourage HRA's HIV/AIDS Services Administration (HASA) to reconsider these policies. It is our heartfelt belief that access to safe and accessible housing is essential to supporting an individual living with HIV/AIDS to adequately address their care and treatment needs.

Thank you for your time and attention.

HOUSING WORKS

General Welfare Committee –
Oversight Hearing on Recent HASA Policy Changes
February 8, 2012

Thank you for the opportunity to testify today on behalf of the staff, clients and volunteers of Housing Works. Housing Works is the largest AIDS advocacy organization in the country, and we have been providing services to people living with AIDS and HIV in New York City since 1990. Housing Works is here today to express concerns regarding recent policy changes at the city's HIV/AIDS Services Administration (HASA) that are affecting clients' ability to find and maintain stable housing.

HASA's new substance use screening policy

On December 1, 2011, Commissioner Doar released information about HASA's new substance use screening policy through an op-ed in the Huffington Post. According to the substance use screening policy, which was implemented in November 2011, new clients, as well as those in arrears who are seeking help with rent or utilities, or clients who are looking to move into a new apartment will be screened for substance use issues, and will be referred to treatment if it is deemed appropriate. Additionally, it appears from the written policy that clients can also be screened at the discretion of the HASA case worker if substance use issues are suspected.

HASA's new policy indicates that clients who are screened for substance use by CASAC staff on site and who are subsequently referred to services will need to be compliant to a substance use program. If a client is not compliant to these services, HASA has now said it has the right to deny arrears payments and the right to deny above enhanced rental assistance for clients' housing. Effectively, clients who are not able to be compliant will be denied access to stable housing, and many will become homeless and end up in costly emergency housing such as SROs or hotels.

Housing Works has a number of concerns with this policy and its impact on HASA clients. First, we are very concerned that clients will only be referred to substance use treatment programs that are abstinence-based. The City has contracted with NADAP, which provides CASAC screenings and referrals to abstinence-based substance treatment programs only. If HASA is going to mandate substance use services, we believe that harm reduction programs must be included in the list of options for clients, and that compliance with harm reduction treatment programs should be considered adherence to drug treatment for the purposes of this policy. The city's Department of Health and Mental Hygiene and the City Council have been supportive of harm reduction programs and services for many years – it would seem appropriate that clients be able to seek services at these programs as an option if complete abstinence from substance use is not possible.

Additionally, HASA has indicated that it will be referring clients who refuse or who are non-compliant with substance use services to supportive housing. Housing Works supports the referral of clients who are facing eviction or arrears to supportive housing, but we seriously question the ability of HASA to commit to this proposed option. First, the Bloomberg administration has proposed millions of dollars in cuts to HASA supportive housing over the last few years; last year's total was a cut for $5.1 million to case management services and provider contracts, which the City Council has had to restore with its own discretionary funding (and which has again not been included in the baseline for FY13). Additionally, HASA has delayed the development of its NY/NY III supportive housing units in several rounds of cuts for the last few years, including a $1.3 million PEG included in this FY13 budget proposal. With current supportive housing operating at full capacity and funding constantly being threatened, it is difficult to believe that HASA is committed to providing much-needed supportive housing to clients who are HIV-positive and deal with substance use issues.

Additionally, it has been communicated that if a client is in arrears or faces eviction, that HASA will refer them to be screened for substance use – the punitive assumption being that substance use is the cause of the client's inability to pay their rent or utility costs. How will HASA separate out drug use as a cause of the arrears as opposed to other causes? The assumption HASA is making about the connection between substance use and arrears does not take into account the significant number of other reasons why clients may fall into arrears. Most notably, clients of HASA who live independently do not have a rental cap of 30% of income. This 30% rent cap protection is provided in all other housing programs, but is not provided for HASA clients living independently. This lack of protection places an enormous rental burden on clients with income such as SSI or SSDI, often leading clients to pay 60-70% of their income towards their rent. This amount is simply not sustainable, and often leads to clients falling into arrears.

Changes to brokers' fee payments and security deposits

In February and March 2011, HRA changed its policy on how it pays brokers' fees and security deposits for clients on public assistance who need to find a new apartment. Brokers' fees were cut to half of one-month's rent, which was a 50% reduction from prior policy. Security deposits are no longer paid in cash, but landlords will be able to be reimbursed for damages with a voucher at the end of the lease.

Immediately upon implementation, this policy became a barrier to stable housing for people living with HIV who receive rental assistance from HASA. In May 2011, a survey was done of case managers at AIDS service organizations across the city, who widely reported that this policy change was having a serious negative effect on the ability of their clients to find apartments. Of the case managers who responded, 94% reported that the brokers' fee change was a significant barrier, with 50% reporting that it had

already prevented placement for one or more of their clients who were looking for housing only two months following the policy change.

Because the majority of HASA clients live in independent housing, many rely on brokers to find stable housing in the independent market. With this change in policy, many brokers and landlords are no longer working with clients who have HRA-sponsored housing. At some agencies, including Housing Works, our case managers have lost valuable brokers and landlords who had been working with clients for many years. Many clients and case managers are reporting that it is taking significantly more time to find stable housing, because so many brokers will not work with them, and landlords will not accept vouchers. For clients in emergency housing, this is especially troubling – SROs are not stable or medically appropriate places for clients to live, not to mention that they are extremely expensive, costing the city on average $55 per night, or $1650 per month. Even one month longer in emergency housing costs more than three times what the city claims it is saving by not paying half of that same client's brokers' fee.

In addition, many brokers are asking clients to pay the other half of the brokers' fee on their own. Out of desperation for stable housing, clients feel pressured to get this money, sometimes taking unnecessary risks to find it, including working with loan sharks, selling their medications, or engaging in prostitution. Clients should not be put in a situation where they feel they must put their health and safety at risk in order to acquire stable housing – stable housing should be provided so that clients do not need to put themselves at risk.

As we continue into budget season, Housing Works urges the City Council to work with the Mayor's Office and HRA to change these policies. If HASA actually wants to "remain as committed as ever to providing the highest quality of service to those living with clinical symptomatic HIV or AIDS," as Commissioner Doar said on World AIDS Day in the Huffington Post, ensuring that these policies actually provide opportunities for stable housing would be an excellent way to show that commitment.

Thank you to the General Welfare Committee for standing strongly with New Yorkers living with HIV/AIDS, and for demanding accountability on these and other policies that hinder our clients' ability to remain housed and healthy. We appreciate your commitment.

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Testimony for City Council General Welfare Committee Hearing on Recent Policy Changes At HASA | February 8, 2012

Broker's Fee Payments & Security Deposits

➔ *VOCAL-NY recommends that HRA rescind the new broker's fee and security voucher policies and rely on cost savings from the reduced length of stay in emergency housing that will result in order to pay for it.*

HASA cut the amount of broker's fee payments by 50%, limiting payments to half the cost of first month's rent, and replaced security deposits with a voucher beginning in March 2011. These policy changes have exacerbated already widespread discrimination against HASA clients in the rental assistance program among landlords and brokers. HASA's rental assistance program, which more than 80% of clients rely on for housing, is the primary source of housing assistance for low-income people living with HIV/AIDS in NYC. Note that the $4.8 million PEG for broker's fee payments included in the FY11 November Financial Plan included all HRA rental assistance programs, not just HASA.

After the policy went into effect, Shubert Botein Policy Associates surveyed 238 case managers at 44 different community-based organizations that assist people living with HIV/AIDS to determine the impact of the policy change. The survey found that 94% of respondents said the broker's fee policy was a "significant barrier" to housing placement, and 50% said it had prevented a placement for one or more clients. Nearly two-thirds of case managers reported that it was taking significantly longer to find an apartment for HASA clients in the rental assistance program after the policy change.

Many brokers are now unwilling to work with HASA clients and their case managers to locate housing due to the lower fee. Other broker's have asked HASA clients to pay the other half of the fee out of their own pockets, forcing clients into precarious situations to obtain the money.

Ultimately, this policy will not save the City money because it will force clients to spend longer periods of time in emergency housing, which cost an average of two to three times as much as the cost of rent in a private market apartment – or three times the purported savings from the reduced broker's fee payment for one month.

Substance Abuse Screening

➔ *VOCAL-NY recommends that HASA rescind this policy and work with clients and community partners to develop a voluntary drug and alcohol screening and referral system offering a full range of evidence-based options. No client should be denied any HASA services because they decline to participate in a recommended drug treatment plan.*

On the eve of World AIDS Day, HRA Commissioner Robert Doar announced via a little-noticed Huffington Post column a "tough" new policy that will deny arrears payments (i.e. one-shot deals) and rental assistance to clients who do not participate in a recommended substance abuse treatment program. Denying one-shot deals or rental assistance leaves clients with only emergency housing or the very limited supply of supportive housing as the only alternative housing options within HASA, and we know there are too few vacancies in supportive housing for that to be a viable option for most clients.

This new policy is certain to increase homelessness, cost unnecessary taxpayer resources (both in terms of emergency housing placements and mandated drug treatment), and make recovery *more* difficult for people with serious drug and alcohol problems. Forcing clients into homelessness if they refuse to participate in a prescribed drug treatment plan is likely to increase problem drug and alcohol use, not reduce it. Therefore, this policy will have the opposite effect of its stated goal of reducing problem drug and alcohol use.

Although HASA has not provided any public details about their screening or referral process, it is likely that the agency is referring clients to a limited range of drug treatment programs that exclude, for example, opioid treatment programs and syringe exchange programs, both of which are evidence-based interventions that reduce illicit drug use and harms associated with use, such as HIV and hepatitis C transmission.

There is a special irony in Commissioner Doar's claim that clients who do not participate in a recommended drug treatment plan can move into supportive housing instead of remaining in their apartment. Mayor Bloomberg has repeatedly cut funding for HASA supportive housing programs, especially case management that focuses on working with clients around substance use. In addition, his FY13 budget proposal would further delay the rollout of NY/NY III supportive housing units for HASA clients who have substance abuse and/or mental health issues.

Reducing HASA Rental Arrears

➔ *VOCAL-NY urges City Council to ask the state legislature and Governor Andrew Cuomo to enact a law creating an affordable housing 30% rent cap protection for HASA clients.*

HASA clients in the rental assistance program, i.e. independent living, are denied affordable housing and suffer from what HUD defines as a "severe rent share burden." About 10,000 clients are now at risk for homelessness because they are forced to pay upwards of 70% or more of their disability income towards rent.

The unsustainable rent burden leads to high rates of rental arrears and recurring homelessness among HASA clients in the program. About 60% of people living with HIV/AIDS in NYC have

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experienced homelessness or unstable housing at least once during the past five years, and about one-quarter are unstably housed any point in time. We know from existing housing programs that low-income people living with HIV/AIDS who have a 30% rent cap protection are much more likely to remain stably housed and avoid falling into arrears, losing their homes and being placed into costly emergency shelters.

The severe rent share burden also forces clients into cruel trade-offs and sacrificing in order to pay their rent. More than 40% of New Yorkers living with HIV/AIDS report not having enough money for food, utilities, or un-reimbursed medical care and health needs at least sometime during the past six months. This hardship is almost universal among HASA clients in the rental assistance program.

Aligning HASA's rental assistance program with all other housing assistance programs in New York (including supportive housing programs within HASA) so that clients pay no more than 30% of their income towards their rent is long overdue, and it would ensure the program meets the federal standard for affordable housing.

City Council has passed several resolutions endorsing state legislation sponsored by Senator Thomas K. Duane and Assembly Member Deborah Glick that would ensure HASA clients pay no more than 30% of their income towards their rent. However, Mayor Bloomberg has been the most outspoken and active opponent against the bill.

Restoring Supportive Housing Funding

➔ *VOCAL-NY recommends that Mayor Bloomberg and City Council restore $5.1 million in annual baseline for HASA-contracted supportive housing programs, which received a one-year restoration by City Council in the FY12 budget.*

Mayor Bloomberg cut nearly $5.1 million in funding for supportive housing programs serving approximately 4,500 HASA clients in the FY12 budget. Although City Council made a one-year restoration in the FY12, the full cut will go into effect this summer unless City Council or Mayor Bloomberg restore funding.

Housing and operations costs are fixed, which means the bulk of the $5.1 million cut would be for onsite case management, undermining the central purpose of the programs. HASA's supportive housing programs, which include permanent congregate and Scatter Site programs, serve about one in seven HASA clients living with HIV/AIDS. These are the most vulnerable HASA clients who have substance use and mental health issues in addition to their HIV/AIDS diagnosis.

Supportive housing programs are proven to increase adherence to healthcare and medication, while dramatically lowering mortality rates and HIV risk behaviors. Research has shown that homeless people living with HIV/AIDS who obtain supportive housing programs have one-third fewer emergency room visits and hospital stays, and are at least twice as likely to have an undetectable HIV viral load. Supportive housing also helps prevent new HIV infections by reducing risk behaviors.

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Oral Testimony by Wanda Hernandez, VOCAL-NY Board Chair

Good afternoon, my name is Wanda Hernandez. I was diagnosed with HIV/AIDS in 1995 and became a HASA client in 2001. I now serve as the Chair of the Board of Directors for VOCAL New York. We are submitting testimony for the record, but I'm going to focus just on the new substance abuse screening policy.

VOCAL supports a voluntary and evidence-based referral system for HASA clients who have problem drug and alcohol use.

But that's not what Commissioner Doar announced last November. He announced a "get tough" policy that will mean more people are placed in costly and unhealthy shelters where they are less likely to take their meds, go to the doctor or practice harm reduction.

Let's be real—this policy isn't about helping people reduce the harm that drugs can cause in their lives. It's a bait and switch to divert attention away from what really drives arrears in HASA – the unsustainable, severe rent share burden that clients like me are forced to pay.

Let me tell you my story of how I fell into arrears and how I first learned of this new policy.

I didn't fall into arrears because I have a drug problem. I have an affordable housing problem. I have a poverty problem.

I pay over 70% of my hard-earned Social Security Disability Income towards rent each month. I ended up in arrears with Con Edison because I can't afford to pay other bills after I pay my rent each month. I can't afford to buy enough food. Food stamps run out by the middle of the month and, because of budget cuts, I no longer qualify for my old food pantry or Ensure nutritional drinks. I can't afford to buy clothes, so I live off of hand-me downs. I often can't afford a metrocard, so I have to reschedule appointments like going to the doctor. Toiletries and over the counter medicines add up before you know it. Something is always breaking down or needs to be replaced, like my blender, my computer or a bedspread. I can't even think about a luxury like going to the movies. Trying to stay afloat takes a toll on my mental health, increases stress, and leads to anxiety attacks that kick up my chronic pain.

It was humiliating and frustrating enough to ask for help from HASA last November when I owed ConEd $700. To be clear, HASA's one-shot program for arrears gives with one hand and takes away with the other. Any assistance you receive is recouped in the future, keeping you in the poverty trap.

Then, HASA told me I had to go to a drug screening appointment before I could get a one-shot deal. I felt degraded and like they violated my privacy. If I hadn't answered the questions appropriately, HASA could have denied me the assistance I needed to stay in my apartment and prevent my utilities from being shut off.

We can't let HASA change the subject when it comes to what's driving arrears among clients like me. The simple solution is a 30% rent cap, which City Council has consistently supported, not a witch-hunt against suspected drug users.

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February 2, 2012
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Summary of Mayor Bloomberg's Proposed HIV/AIDS Cuts in the FY13 Budget

Mayor Bloomberg released his preliminary FY13 budget proposal on February 2nd, 2012 and **failed to restore funding for HIV/AIDS supportive housing case management, broker's fee payments, rental assistance, prevention and food and nutrition programs.** If enacted, VOCAL-NY believes these cuts will increase homelessness and make it more difficult for HASA clients to access permanent housing, along with undermining other progress our city has made in the fight against HIV/AIDS.

Note that **the state provides a 27% match for most HASA spending**, so the mayor's proposed cut will trigger an additional loss in state funding.

Although City Council restored some of the worst HIV/AIDS cuts in the FY12 budget, they were for one-year. If they are not restored again in the FY13 budget, they will take effect on July 1st.

Here is a list of PEGs that were not restored in the mayor's preliminary FY13 budget.

Supportive Housing - $5.086 Million PEG

City Council restored a $2.718 million PEG for supportive housing case management and $2.368 million PEG for across-the-board cuts to supportive housing contracts in the enacted FY12 budget, which would impact permanent congregate and Scatter Site programs. There were 4,524 HASA-contracted supportive housing units, including NY/NY III, as of December 2011. Mayor Bloomberg first proposed cutting HASA supportive housing contracts in the FY10 budget (and doubled the proposed cut last year), although City Council has restored most of the funding each year since then.

NY/NY III Supportive Housing Delay - $1.355 Million PEG

Mayor Bloomberg's one-time PEG of $1.355 million would further delay the rollout of NY/NY III supportive housing units for people living with HIV/AIDS with a history of chronic homelessness and mental health and/or substance use issues. HASA's NY/NY III

units have been delayed longer than any other City agency involved with the initiative and is now at risk of missing the deadline agreed to for developing 1,000 new units of HIV/AIDS supportive housing over ten years.

Broker's Fee Payments - $4.8 million PEG

Beginning in March 2011, HASA cut broker's fee payments by 50% to no more than half the cost of first month's rent. This exacerbated already widespread discrimination by private market landlords against HASA clients in the rental assistance program, which more than 80% of HASA clients rely on for housing. The $4.8 million PEG includes the new broker's fee policy for all HRA rental assistance programs, not just HASA. Mayor Bloomberg first introduced this PEG as midyear cut in the FY 11 budget and City Council did not make a restoration in the FY12 budget.

HIV/AIDS Rental Assistance - $1.257 million PEG

As noted above, most HASA clients rely on the rental assistance program for housing. Mayor Bloomberg first proposed this cut to the rental assistance program in the FY12 (current year) budget, which was not restored by City Council. HASA has not released an official explanation of how this cut is being implemented, but has explained at meetings that it will be through a diversion process that tries to keep newly enrolled clients in their current housing situation. City Council did not restore this PEG in the FY12 budget.

Food & Nutrition (Project Momentum) - $995,000 PEG

Mayor Bloomberg has also repeatedly tried to shut down Momentum's food and nutrition programs. This funding supports their efforts to provide over 40,000 hot meals per year to persons living with HIV, along with approximately 29,000 pantry bags that provide an additional 353,000 meals. City Council made a one-time restoration of funding in the enacted FY12 (current year) budget.

HIV/AIDS Prevention - $1.406 million PEG

The mayor's midyear budget cuts for the FY12 (current year) budget reduced funding for HIV prevention programs, which is continued in his preliminary FY13 budget proposal.

Raising Revenue = An Alternative to Cuts

VOCAL-NY is again working with a diverse coalition of community, human services and labor union allies to counter Bloomberg's proposed cuts with a focus on raising revenue from Wall Street and corporations. Mayor Bloomberg can raise about $500 million in revenue as an alternative to budget cuts by closing corporate tax loopholes, ending unearned subsidies for big banks, and trimming city contracts with big banks.

THE LEGAL AID SOCIETY

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Testimony to the
New York City Council
General Welfare Committee
on Policy Changes at
HIV/AIDS Services Administration (HASA)

February 8, 2012
250 Broadway, New York, NY

Good Afternoon. My name is Helene Busby; I am a staff attorney at The Legal Aid Society's Civil Practice HIV/AIDS Representation Project. I appreciate the opportunity today to address our concerns about The HIV/AIDS Services Administration's (HASA) new policy regarding mandatory drug screening for HASA recipients. This new policy will result in increased evictions of our medically vulnerable clients from decent affordable housing. Additionally, we wish to submit our concerns regarding recent Human Resources Administrative (HRA) policy changes related to payment of broker's fees and security deposits for public assistance recipients moving into new apartments. These new policies deter landlords and brokers from working with low-income New Yorkers seeking decent affordable permanent housing.

The Legal Aid Society is the nation's oldest and largest not-for-profit legal services organization. It is more than a law firm for clients who cannot afford to pay for counsel. The Legal Aid Society is an indispensable component of the legal, social and economic fabric of New York City – passionately advocating for low-income individuals and families across a variety of civil, criminal and juvenile rights matters, while also fighting for legal reform. The Legal Aid Society has performed this role in City, State and federal courts since 1876. It does so by capitalizing on the diverse expertise, experience, and capabilities of 900 of the brightest legal minds. These 900 Legal Aid Society lawyers work with 600 social workers, investigators, paralegals and support and administrative staff. Through a network of borough, neighborhood, and courthouse offices in 25 locations in New York City, the Society provides comprehensive legal services in all five boroughs of New York City for clients who cannot afford to pay for private counsel.

The Society's legal program operates three major practices — Civil, Criminal and Juvenile Rights — and receives volunteer help from law firms, corporate law departments and expert consultants that is coordinated by the Society's Pro Bono program. With its annual caseload of more than 300,000 legal matters, The Legal Aid Society takes on more cases for more clients than any other legal services organization in the United States. And it brings a depth and breadth of perspective that is unmatched in the legal profession. Our Civil Practice has offices in every borough of the City, and worked on more than 43,000 individual legal matters last year benefiting more than 100,000 clients and their family members and winning over 90 percent of the cases that go to court or an administrative hearing. An additional two million individuals benefit from the Civil Practice's pending class action litigation.

The Civil Practice works to improve the lives of needy New Yorkers by helping vulnerable families and individuals on issues ranging from health care, housing, homelessness prevention, employment law, education, foreclosure prevention, consumer law, community economic development, public assistance, immigration, family law and domestic violence and disability-related issues. Each year, The HIV/AIDS Representation Project (H/ARP) serves hundreds of individuals living with HIV/AIDS by providing comprehensive civil legal services as well as referrals to health services, HIV/AIDS education, counseling, and other services.

Most often HASA recipients apply for special grants, such as rent arrears or moving expenses, because they pay most of their monthly income towards rent or experience unforeseen emergencies, and not due to substance abuse.

Preventing homelessness of HIV positive low-income New Yorkers is a main area of advocacy and representation provided by The Legal Aid Society's HIV/AIDS Representation Project. Through representing thousands of clients, we have learned that there are many reasons why our clients might fall behind in rent and are then at risk for eviction.

HASA recipients who receive Social Security Disability Insurance or Supplemental Security Income (SSDI or SSI) often pay the majority of their monthly income towards rent. In 2010, the New York State Legislature passed a bill that capped the rent for HASA recipients at 30% of their monthly income, but Governor David Patterson vetoed this measure. We have no doubt that enactment of the 30% cap for our clients would go far in preventing homelessness, and reducing the need for our clients to seek rent arrears. The reality is that it is exceedingly difficult to live on $359 a month in New York City. The struggle to keep up each month with these exorbitant rent payments is a major reason HASA recipients accumulate rent arrears.

Often administrative errors cause HASA to inexplicably stop or reduce paying the agency's portion of the rent directly to landlords. Generally, my clients are unaware that they have accrued rent arrears until they receive a nonpayment petition and are facing eviction in Housing Court. We have advocated for clients where rent arrears accumulated because HASA case managers neglected to properly implement lease renewal increases.

Additionally, HASA recipients fall behind on their rent for the same reasons that impact many other low-income New Yorkers. For example, a family emergency will necessitate a last minute trip out of town to visit an ailing family member. Or to ensure the most thorough possible remediation of bed bugs in their apartments, my clients will often incur expenses above what a landlord will agree to pay. These are just some examples of how the vagaries of life especially impact low-income HASA recipients, and will cause them to occasionally need assistance with rent arrears.

In contrast, substance abuse is not a frequent reason why our clients need special grants such as rent arrears or moving expenses. In those occasional cases in which substance abuse does play a role, we will offer referrals to supportive services to help the individual address those issues while we make every effort to prevent the person from being evicted and rendered homeless. The commitment to stable medically appropriate housing contained in Local Law 49 is the most

fundamental means for ensuring the health and well being of all of our clients, especially for clients who need to address addiction issues.

HASA has produced no clear explanation as to why this new policy was deemed necessary. Is the purpose to save the agency money by limiting special grants for rent arrears, moving expenses, and/or ongoing above-enhanced exception to policy rents? Is the point to help HASA recipients' access treatment for substance abuse? Has there been any inquiry as to whether coercing individuals into treatment and threatening them with homelessness is an effective way to bring them into treatment? We are certain that this new policy will leave many HASA recipients in serious jeopardy of eviction. It is important to fully vet and interrogate the wisdom of this policy change due to its potential to negatively impact the health and welfare of low-income HIV positive New Yorkers.

Delays granting rent arrears puts HASA recipients at risk of eviction from affordable decent housing.

The new policy requires mandatory substance abuse screening before HASA will approve and issue special grants such as rent arrears, moving expenses or approve or continue to pay above-enhanced rental assistance. Before this policy there already existed a multi-step process for HASA recipients to apply for special grants. In all cases the HASA recipient must meet with their HASA case manager who will collect information related to the request, evaluate the HASA recipient's application for a special grant, and have the individual sign paperwork to complete the request. Even before this new policy, delays abounded; due to heavy case loads many case managers are in the field two days a week and unavailable to process these requests and our clients have limited availability to visit HASA due to their numerous medical appointments.

In our experience, any needless delays put HASA recipients in danger of eviction because of the fast pace of summary proceedings in Housing Court. Especially for HASA recipients unrepresented in Housing Court, delays in issuing rent arrears can cause individuals to fall through the cracks. For example, if arrears are not issued by HASA by a court ordered payment deadline and the person is too ill or weak to file a *pro se* Order to Show Cause at Housing Court, then the person will be evicted.

In practical terms we are concerned that the screening and possible referral to a Certified Alcohol and Substance Abuse Counselor (CASAC) will add further delays. We currently lack the full details of how HASA intends implement this policy. However, it is our understanding that if a HASA case manager suspects that an individual may have a substance abuse issue, the person will be first screened by the case manager, and then referred to a CASAC. The CASAC will evaluate and determine whether the individual needs substance abuse treatment and the nature of the treatment. It is unclear how much additional time the CASAC evaluation will add to the process of issuing special grants. It is unclear what will trigger a referral to CASAC. If a person admits to having a drug history, will that trigger the referral? Will case managers make unnecessary referrals out of an abundance of caution? This will delay the issuance of special grants and put the HASA recipients at risk of eviction.

The HRA Commissioner's policy announcement in the Huffington Post indicates that no special grants or above-enhanced rental assistance will be issued by HASA "until proof of substance abuse treatment is established." This raises the question of what is required to demonstrate that the substance abuse treatment is established. Will agreement by a HASA recipient to go to treatment be sufficient? Will the person have to actually begin the treatment or progress to a certain benchmark in the treatment? Or will the person have to complete treatment before receiving a special grant and/or the full ongoing rent for their apartment? These questions highlight the possibility of delays of unknown duration that can derail an individual's ability to maintain medically appropriate affordable housing. Based on my experience representing tenants in Housing Court, I can say that very few landlords will be patient enough to wait weeks or months for their money before sending a Marshal to evict a tenant in arrears.

The new policy should, but apparently does not, offer additional supportive housing placements, which are desperately needed by many eligible for HASA.

The Commissioner's announcement stated that if HASA recipients did not agree to participate in the recommended drug treatment that they would be either denied special grants and/or above-enhanced rental assistance, or "they will be offered a supportive housing placement." The process for placing HASA recipients, who urgently need additional services, in appropriate and decent supportive housing is often long and arduous. Due to lack of resources and tremendous demand, we have seen clients try for months if not years to access supportive housing. They have to repeatedly apply for spots and visit possible placements only to find out that the spot they were referred to was just filled.

Unfortunately, we have learned that the supportive housing offer mentioned in the Commissioner's statement does not in fact refer to any additional supportive housing placements. For some reason, HASA does not anticipate additional need for supportive housing as a result of this policy. This is hard to understand since this policy will likely result in a rise in evictions and homelessness of HASA recipients. This also raises the important question – where will homeless HASA recipients go if not to supportive housing? The only answer we can imagine is that these individuals, who HASA has identified as being in need of substance abuse treatment, will be referred to transitional housing in the various commercial Single Room Occupancy (SRO) units in the City.

A policy that ultimately results with individuals susceptible to substance abuse being transferred from stable long term apartments to SROs is not a policy that can legitimately claim to be designed to help impacted HASA recipients overcome addiction. Anyone who has spent time in such SRO buildings understands that there is often drug use in these buildings and thus they are inappropriate placements for someone with an addiction history or inclination. Many of these facilities have such awful conditions that it is difficult to believe they could be fairly categorized as meeting the standard for medically appropriate housing required by Local Law 49. Furthermore, these substandard units in buildings where drug use is common regularly cost from $2,000 to $2,500 a month. This is more than twice the monthly rent that HASA pays for the majority of my clients to live in their own private apartments. We question the wisdom of this policy as it will cost the City much more to house our clients in SROs, then to help them maintain reasonably priced medically appropriate housing.

The HRA policy implemented last year which limited moving related grants for broker's fees and security deposits critically reduces the opportunity for HASA recipients to access decent affordable housing.

As of February 1, 2011, HRA stopped issuing security deposits for public assistance recipients moving into new apartments, and instead required that landlords accept a voucher promising possible payment when the public assistance recipient vacated the apartment. As of March 1, 2011, HRA reduced by half payment to brokers who assist public assistance recipients secure new apartments. These policies have wreaked havoc on the ability of all New Yorkers on public assistance, including HASA recipients, to access decent housing. For our clients on HASA, these policy changes have made the already challenging process of obtaining good quality housing in this expensive City nearly impossible.

Based on the limited supportive housing options, and the often problematic conditions found in SROs, most of our clients need to obtain private rent stabilized or market rate apartments. Our clients have always faced a number of problems obtaining housing as they must compete for apartments against individuals with employment income. Also, HASA recipients might lose out on apartments if they had a previous Housing Court case or if they have less than stellar credit. One big impediment is that HASA has essentially capped approvals of the above-enhanced rental assistance for individuals at $1,000 per month or less. It is rapidly becoming difficult for our clients to find apartments in any Borough of New York for that amount.

In the past, many of our clients have utilized the assistance of brokers to obtain apartments with prices that HASA would approve. The new policy is a disincentive for brokers to work with HASA recipients as they will only receive half of their usual fee for assisting our clients. The HRA policy states that brokers are not to try to obtain the balance of the broker's fees from our clients, but we have no doubt that this happens anyway. Regardless, most of our clients would not be able to pay half of the broker's fee on their own from their subsistence level of monthly income.

Similarly, the policy that ended payment of security deposits to landlords limits our clients' ability to secure apartments. HASA is asking landlords to accept a voucher that puts the burden on the landlords to demonstrate that they are entitled to recover for damage or unpaid rent after the tenant vacates. After the City recently broke its promise to guarantee payment of Advantage subsidies to landlords, one could not fault landlords for being skeptical as to whether they would get payment based on these vouchers. I know of cases where even after the landlord accepts an individual as a tenant, they continue to prod and cajole the tenant for direct payment of the security deposit.

Finally, this policy cannot make sense financially, and must be actually costing in excess of any purported savings. HASA recipients' reduced ability to access decent private housing leaves many individuals with no other options than remaining in SRO units for months or years. Generally, HASA pays $2,000 to $2,500 per month for these poor quality units, while a private apartment will only cost HASA $1,000 per month or less. Thus, it would be in HASA's best interest to have policies that encourage recipients' efforts to access private apartments. Besides

the cost savings to HASA, easing the way for recipients to move into private apartments helps fulfill the promise of Local Law 49 by housing this vulnerable population in decent medically appropriate apartments.

Conclusion.

We thank the Council and its leadership for calling this hearing, and we look forward to answering any questions and working with you in the future.

Respectfully Submitted,

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SHUBERT BOTEIN **POLICY ASSOCIATES**

Testimony of Virginia Shubert before the
New York City Council Committee on General Welfare
February 8, 2012

Thank you, Chairperson Palma and members of the Committee on General Welfare, for this opportunity to testify before you. My name is Virginia Shubert, and I am a principal of Shubert Botein Policy Associates, a public policy consulting group.

I will briefly address two issues today – both related to the availability and ongoing effectiveness of the program of NYC/NYS enhanced rental assistance for persons with advanced HIV disease that is administered by HRA's HIV/AIDS Services Administration (HASA). I also attached two documents for your review: 1) a July 2011 report of findings from a survey of community-based case managers examining the impact of HRA/HASA rental assistance policies on New Yorkers living with HIV/AIDS; and 2) the 2011 Policy Paper from the North American Housing and HIV/AIDS Research Summit Series, entitled "Evidence into action: Housing is HIV prevention and care."[i]

Tenant based rental assistance is historically – by far – the most significant type of housing assistance provided for poor New Yorkers living with AIDS/AIDS. Over 80% of the HASA clients who currently rely on public assistance for permanent housing support – over 25,000 households – live independently with the help of rental assistance. This assistance is made possible by the enhanced rental assistance for persons with HIV/AIDS established in the mid-1980s by New York State regulation. Title 18, Section 397.11 of the codes, rules and regulations of New York State provides for enhanced rental assistance for individuals and families with clinical, symptomatic HIV illness. Equally important are the long-standing HASA practices of approving "above-enhanced" rental payments in line with NYC fair market rents (21,000 households receive above-enhanced assistance), and of paying broker fees and security deposits to enable HASA clients to secure housing in the NYC market. This program is unique in its reach and effectiveness and has made NYC a leader in HIV housing.

NYC has also been a leader in taking a public health approach to housing for people with HIV. Many people living with and at risk of HIV infection and other chronic conditions are barred from housing resources due to stigma, eligibility requirements, and/or the co-occurring issues, such as histories of incarceration and active drug use, that make them most vulnerable. For this subset of homeless persons, providing housing and services without requiring abstinence or treatment is significantly more effective for the individual and the community than allowing them to remain homeless. A public health approach: lifts public housing exclusions based on status, such as a history of incarceration or active drug use; promotes housing for chronically ill persons regardless of disease stage, active substance use, or minimum income; and ensures the availability of assistance to overcome

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barriers to housing access and stability, including barriers related to drug use, mental health and lack of income.

Brokers fees and security deposits

During May 2011 consultants Shubert Botein Policy Associates (SBPA) developed and administered an online survey of NYC case management providers who assist HASA clients to find and secure private market housing. The survey was designed to gather data about how the new HRA policies on security deposits and brokers fees are affecting the ability of NYC households living with HIV/AIDS to secure housing. Respondents were asked to share their experiences with the new policies and those of their clients living with HIV/AIDS, but not to share client names or other identifying information. A link to the survey instrument was distributed widely on May 17th – primarily to COBRA providers across the City. Responses were collected during the 2-week period ending June 1st.

In just two weeks SBPA collected 238 responses from case managers at 44 different community-based agencies. The majority of responses are from COBRA case management program staff members, but respondents reflect a wide range of medical and supportive services providers who work with PLWHA in all five boroughs of the City – including hospital-based medical case managers, housing placement specialists, discharge planning staff, and other direct service providers.

Respondents report that a significant percentage of their current clients are homeless or unstably housed and actively seeking housing; 63% of respondents report that more than half of their clients are involved in a housing search at any given time.

Survey respondents report that the recent changes in HRA rental assistance policies have significantly affected the PLWHA they serve, with the brokers' fee change being the most damaging.

- Over 95% of clients involved in a housing search have experienced one or both policy changes as a barrier to housing placement;
- 79% of respondents report that the security deposit change poses a significant barrier to their clients;
- 94% report that the brokers' fee change is a significant barrier, with 50% reporting that it has prevented placement for one or more clients;
- 61% of the case managers who responded to the survey report that, compared to this time period last year, it takes significantly longer to find and secure an apartment using the HASA rental assistance program.

Substance use screening

Perhaps even more disturbing is the announced plan to condition access to rent arrears payments and market rate rental assistance to adherence to abstinence based substance use treatment. Of course, every PLWHA should have access to services to address harmful drug use – that has always been a requirement of good HASA case management. However, there is no scientific evidence to support compliance with drug treatment as a condition of basis survival needs. To the contrary, for PLWHA the evidence points to housing assistance

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as a more powerful predictor of health care access and good health outcomes than drug use, mental health status or other individual characteristics.

As outlined in the attached Policy Paper, rigorous study has shown that housing supports create stability and connection to care for people living with HIV/AIDS (PLWHA) regardless of co-occurring issues – improving health, reducing individual behaviors that can transmit HIV, and sharply reducing the individual and public costs of avoidable emergency room visits and inpatient care. Both the National HIV/AIDS Strategy and the Federal Strategic Plan to Prevent and End Homelessness recognize housing as an evidence-based HIV prevention and care intervention, and both plans call for policies and practices that incorporate housing assistance as a critical component of health care.

The announced policy to exclude "noncompliant" HASA clients from market based rental assistance is effectively a denial of rent supports based on drug use. This is especially troubling as the Mayor's office has consistently opposed an affordable rent cap for disabled HASA clients that would in fact increase stability in housing.

Indeed, according to the Columbia University "CHAIN" study funded by the NYC Department of Health & Mental Hygiene (DOHMH) among PLWHA in NYC who receive rental assistance, those who have never used hard drugs are no less likely than persons with recent drug use to report ongoing difficulty with meeting rent obligations – 25% and 27% respectively. These persons are equally likely to be food insecure - consistent with what we see in national studies since persons with difficulties meeting housing costs (paying rent or mortgage) will skimp on spending for food with deleterious consequences for their health, especially among those with chronic illness.

As with NYS housing programs for other disabled people, enhanced rental assistance program participants with income from disability benefits contribute a portion toward rent. Unlike other programs, however, the HIV/AIDS rental assistance program put in place in the 1980's does not include an affordable housing protection. All other state and federal disability housing programs – including most HIV/AIDS supportive housing – cap a tenant's rent contribution at 30 percent of income. In contrast, the NYS OTDA requires that persons with HIV/AIDS who receive income from any source be budgeted for the rental assistance program at a rent level that reduces their discretionary income to the level of the public assistance grant. Permanently disabled PLHWA are therefore required to contribute between 50% and 75% of their fixed income from disability benefits (SSI, SSDI, or Veteran's benefits) towards their rent, leaving less than $12/day to meet all other expenses. HUD defines payment of more than half of income towards rent as a "severe rent burden."

This policy has two pernicious impacts. First, it causes tenants to fall behind in rent leading to housing loss and disruption of care. Second, the policy acts as a powerful disincentive to independence, as more stable residents opt to enter or stay in supportive housing in order to reduce their rent burden. As a result, there is very little turnover in the permanent supportive housing system, keeping people with more complex needs homeless. At any given time, over 1,800 HASA clients are in emergency housing, with 900 relegated to dangerous and costly single room occupancy hotels.

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Pending legislation (overwhelmingly passed by both Houses of the NYS Legislature but vetoed by former Gov. David Patterson) would cap rent contributions for extremely poor, chronically ill New Yorkers at 30 percent of their disability income. Thirty percent of income is the widely accepted standard for housing affordability among low-income persons, and research shows that capping the rent burden at 30% will have a dramatic impact on rates of non-payment and subsequent housing loss. A 2009 study by researchers at Harlem United compared the rates of payment of the client's rent share in two of their HIV housing programs – a federally funded program with rent burden capped at 30% of disability income, and a program that utilizes the State/local rental assistance program with no rent cap. They found that clients with the 30% affordable housing protection where more than twice as likely to make timely rent payments than persons with no rent cap (83% vs. 41%).

An affordable housing protection is also cost-effective. Reducing housing loss and freeing up existing supportive units will pay for this legislative change before even taking into account anticipated Medicaid savings from avoided crisis health care and prevented HIV infections. In NYC, we estimate that the $20.7million incremental annual rental assistance cost to the City and State but would be offset by annual cost savings of at least $21million in averted rent arrears payments and emergency housing costs. While it is more difficult to calculate the direct additional benefits in reduced Medicaid costs, we estimate annual savings conservatively at $50million ($22.5million in averted crisis health care and $27.8million through prevention of new HIV infections).

We urge HASA to support evidence-based, cost-effective housing strategies that will advance the agencies primary responsibility – to ensure that all New Yorkers living with HIV disease are connected to HIV care and are able to satisfy basic human needs.

[i] Also available at www.hivhousingsummit.org

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EVIDENCE INTO ACTION: HOUSING IS HIV PREVENTION AND CARE

Policy Paper from the North American Housing and HIV/AIDS Research Summit Series 2011

"First, we need to let science guide our efforts....Facts are stubborn things and we need to keeping putting them out there...." [1]

OVERVIEW

To prevent and treat HIV/AIDS in North America, we must end homelessness and housing instability for people living with and at risk of HIV infection. Prevention and care efforts that focus on changing individual behaviors are doomed to fail for persons who lack access to a proven, cost effective health intervention – a safe secure place to live.

Combination antiretroviral therapy (ART) can effectively manage HIV disease and dramatically reduce ongoing HIV transmission – yet in North America where ART is relatively easy to access, the ongoing 30-year AIDS crisis is marked by stalled prevention efforts and worsening HIV health disparities. These health inequities are driven by poverty, place, and other structural factors that "shape and constrain" individual behaviors.

According to a large and growing body of research, housing status has a direct, independent, and powerful impact on HIV incidence and on the health of people living with HIV/AIDS. Homelessness and unstable housing are consistently linked to greater HIV risk, inadequate HIV health care, poor health outcomes and early death. In fact, housing status is a stronger predictor of HIV health outcomes than demographics, mental health, substance use, or use of other services. Whatever factor makes someone vulnerable to HIV infection – homelessness magnifies the risk. Whatever factors lead to disparities in care – for women, for youth, for sexual minorities, for people of color, for those who experience mental illness, addiction, violence, abuse or incarceration – housing instability amplifies these disparities in tragic and avoidable ways.

Housing instability is a significant social driver of HIV health inequities in North America that can be addressed by investing in housing interventions. Housing supports create stability and help connect people to care – improving health, reducing behaviors that lead to HIV transmission, and sharply cutting the cost of avoidable emergency room visits and inpatient care. Innovative "low-threshold" housing models achieve these results regardless of all other co-occurring behavioral issues. Health care savings realized by preventing HIV infections and reducing use of crisis care can offset all or part of the cost of housing, making housing assistance a cost-effective HIV prevention and care intervention. In fact, public action to address the unmet housing needs of persons living with HIV/AIDS costs far less than inaction.

The published evidence on the effectiveness of housing assistance as HIV health care is more substantial than the evidence for many widely accepted health care interventions.[2] Yet housing supports are still considered an "ancillary" HIV service rather than a core prevention and health care intervention. Given what we know about the impact of housing on HIV prevention and care,

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[1] U.S. Secretary of State Hillary Rodham Clinton, Remarks on "Creating an AIDS – Free Generation," National Institutes of Health, November 8, 2011.

[2] Remarks given at North American Housing and HIV/AIDS Summit IV by Dr. David Holtgrave, Johns Hopkins Bloomberg School of Public Health, June 2009, Washington, D.C.

providing stable housing for people with or at high risk of HIV is a moral/human rights issue, a public health issue, and an issue of fiscal responsibility. We need a new policy and practice paradigm: one that recognizes housing interventions as a core HIV health activity, and builds a strong bridge between the housing and health sectors. The housing sector must be a key partner in any serious effort to reduce health inequities, and the health sector must invest in housing as a cost-effective, evidence-based HIV prevention and care strategy.

Following the evidence: the Housing and HIV/AIDS Research Summit Series

The HIV/AIDS Research Summit Series – spearheaded by the U.S. National AIDS Housing Coalition (NAHC) [3] and the Ontario HIV Treatment Network (OHTN)[4] – provides a dynamic, interdisciplinary forum to synthesize and disseminate research on the role of housing in HIV prevention and care, and to discuss evidence-based housing policy and practice. The sixth North American Housing and HIV/AIDS Research Summit, held September 21-23, 2011, in New Orleans, Louisiana, brought together over 300 researchers, policy makers, service providers and people living with HIV/AIDS from across the United States, Canada, the Caribbean and Mexico. It was convened by NAHC and the OHTN in partnership with the U.S. Department of Housing and Urban Development (HUD) Offices of HIV/AIDS Housing (OHAH)[5] and Policy Development and Research (PD&R).[6] Academic partners included the Johns Hopkins Bloomberg School of Public Health, the Tulane University School of Public Health and Tropical Medicine and the Mexican Instituto Nacional de Salud Pública (National Institute of Public Health).

Summit products include:

- the November 2007 special "Housing and HIV" issue of the journal *AIDS & Behavior*
- online Summit Series resources including issue fact sheets
- a searchable database of over 300 peer-reviewed journal articles on the relationship of housing status and HIV health outcomes.

See www.hivhousingsummit.org.

Summit VI – *Eliminating HIV Health Disparities* – focused on the potential of housing interventions as a strategy to reduce inequities in HIV transmission and health outcomes. Participants shared new findings and worked across disciplines to translate the evolving evidence on housing and health into concrete action strategies to inform policy, practice and ongoing research. [7] This paper summarizes the key research findings and their policy implications.

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[3] The National AIDS Housing Coalition, Inc (www.nationalaidshousing.org) is a 501(c)(3) organization formed in 1994 to assert the fundamental right of all persons living with HIV/AIDS to decent, safe, affordable housing and supportive services that are responsive and appropriate to their self-determined needs.

[4] The OHTN (www.ohtn.on.ca) is an independently incorporated, not-for-profit organization funded by the AIDS Bureau, Ontario Ministry of Health and Long-Term Care. The OHTN acts as a collaborative network of people living with HIV/AIDS, health care providers, consumers, researchers, community-based organizations and government, with a mandate to provide leadership and to advance policy relating to the optimal treatment and care of people living with HIV in Ontario.

[5] The Office of HIV/AIDS Housing (OHAH) works with other HUD offices to ensure that all HUD programs and initiatives are responsive to the special needs of people with HIV/AIDS. One of the primary functions of OHAH is to administer the federal Housing Opportunities for Persons with HIV/AIDS (HOPWA) program through providing guidance and oversight.

[6] The Office of Policy Development and Research (PD&R) supports HUD's efforts to help create cohesive, economically healthy communities. PD&R is responsible for maintaining current information on housing needs, market conditions, and existing programs, as well as conducting research on priority housing and community development issues. The Office provides reliable and objective data and analysis to help inform policy decisions.

[7] Summit VI action strategies can be found at www.hivhousingsummit.org. NAHC and the OHTN engaged Virginia Shubert of Shubert Botein Policy Associates (www.shubertbotein.com) to help plan the Summit VI program and to prepare this policy paper. NAHC and OHTN are solely responsible for the accuracy of the statements, opinions, and interpretations contained in these materials. Such statements, opinions, and interpretations do not necessarily reflect the views of the U.S. Government or the views of the U.S. Department of Housing and Urban Development.

HOUSING NEED DRIVES HIV HEALTH DISPARITIES

The North American HIV epidemic is increasingly concentrated in low income and marginalized communities. (ONAP 2010; PHAC 2010) Members of racial, ethnic and sexual minorities account for the majority of people living with HIV/AIDS, new HIV infections, new AIDS diagnoses, and AIDS deaths. (Prejean, et al. 2011; PHAC 2010) In Canada, Aboriginal people and people from HIV-endemic countries are disproportionately represented in the HIV epidemic. (PHAC, 2010) In the U.S., Blacks account for only 14% of the population but 44% of new HIV infections, and the HIV infection rate among Black women is 15 times the rate of infection among White women. (CDC, 2011) In the U.S., young people (ages 13 to 29) are at particular risk where they accounted for 39% of new infections in 2009. (Prejean, et al. 2011) In Mexico and the Caribbean, mobile populations and persons displaced by economic conditions or natural disasters are often excluded from care, and experience high rates of HIV infection, morbidity and mortality. (Boucicaut & Ghose, 2011; Infante, 2011)

Recent U.S. research points to poverty – not race – as the most significant factor contributing to HIV health inequities. According to U.S. Centers for Disease Control and Prevention (CDC) surveillance data, heterosexual men and women in 23 major U.S. cities living below the poverty line are twice as likely to have HIV infection (2.4%) as those living above it (1.2%), and other social determinants of health—including homelessness, unemployment, and low education level—are also independently associated with HIV infection. (Denning & Dinenno, 2010)

Housing is the greatest unmet need of people with HIV

Housing instability is a key marker of extreme poverty, and is both a cause and an effect of the ongoing AIDS crisis in North America. Rates of HIV infection among homeless persons are as much as 16 times higher than in the general population (Denning & Dinenno, 2010; Kerker, 2005; Roberson, 2004; Culhane, 2001), and at least half of all persons living with HIV report experiencing homelessness or housing instability following diagnosis. (Aidala, et al., 2007; Bacon, et al., 2010)

Housing is consistently cited as the greatest unmet need of North Americans living with and at high risk of HIV. (NAHC, 2011; Bacon, et al., 2010) In the U.S., at least 140,000 households living with HIV have a current unmet housing need . (NAHC 2009) For example, 38 % of people living with HIV/AIDS surveyed for an Alabama statewide needs assessment reported being unstably housed after diagnosis, and almost 30% of Black males and 20% of Black females living with HIV in Alabama had experienced chronic homelessness in the last three years. (Bennett & Hiers, 2011) Almost half (42%) of a large cohort of persons living with HIV in Ontario have difficulty meeting housing costs, and one in three are at risk of losing their housing. (Bacon, et al., 2010)

Housing instability = greater HIV risk and poor health outcomes

Housing status is also a key determinant of worsening HIV health disparities. Among persons at greatest risk of HIV infection (e.g., men who have sex with men, persons of color, homeless youth, people who inject drugs, and impoverished women), those who lack stable housing are significantly more likely to acquire HIV over time. (Marshall, 2009; Denning & DiNenno, 2010; Marshall, 2011) Even in communities of concentrated poverty, the rate of new HIV infections is almost twice as high (1.8 times) for persons with a recent experience of homelessness, compared to those with stable housing. (Denning & Dinenno, 2010)

For people living with HIV, homelessness and unstable housing are strongly associated with inadequate HIV health care, poor health outcomes and early death. (Wolitski, et al., 2007) Compared to their peers who are stably housed, persons living with HIV who lack stable housing:

are more likely to delay HIV care; have poorer access to regular care; are less likely to receive optimal antiretroviral therapy; and are less likely to adhere to therapy (Kidder, et al., 2007; Aidala, et al., 2007; Leaver, et al., 2007). Homeless people with HIV experience worse overall physical and mental health than their housed counterparts, have lower CD4 counts and higher viral loads, and are more likely to be hospitalized and use emergency rooms. (Kidder, et al, 2007) Homelessness is independently associated with HCV/HIV co-infection (Rourke, et al. 2011), and the death rate due to HIV/AIDS is seven to nine times higher among homeless persons than in the general population. (Kerker, 2005; Walley, et al, 2008; Schwarcz, et al., 2009)

Why is housing so critical? Because having a safe secure place to live is fundamental to the basic activities of daily living. When one is homeless or facing housing instability, immediate survival takes priority over other activities and choices. The stresses of the environment are relentless. Violence is ubiquitous, and stable intimate relationships are all but impossible. Homelessness degrades one's very identity.

The most vulnerable persons also face the greatest risk

People living with HIV who are members of marginalized groups and those with co-occurring needs are most heavily affected by both housing loss and HIV health disparities. Aboriginal people living with HIV/AIDS in Ontario are three times more likely than their Caucasian counterparts to have experienced homelessness, and are only half as likely to be on anti-retroviral therapy. (Monette, et al. 2011) More than half of HIV-positive inmates released and then re-incarcerated in the San Francisco jail system in a 12-month period were homeless in the month preceding re-incarceration, and 59% of those with a history of antiretroviral use were not taking HAART. (Clements-Nolle, et al., 2008) Among people who inject drugs in a Canadian setting where HIV care is free, only homelessness and frequent heroin use were significantly negatively associated with ART adherence after adjusting for sociodemographics, drug use, and clinical variables. (Palepu, et al. 2011) An ongoing study of U.S. veterans living with HIV shows that 42% have experienced homelessness, 11% are currently homeless (compared to fewer than 1% for veterans in general), and (controlling for other factors) HIV-positive veterans who have experienced homelessness are significantly less likely to adhere to HAART and are more likely to be hospitalized than housed veterans living with HIV. (Ghose, et al., 2011; Gordon, et al., 2007) A large multisite study of people receiving HIV care in eight U.S. urban centers found that 43% of persons triply diagnosed with HIV, substance use and mental health issues currently lacked stable housing. (Conover, et al. 2009)

To stop HIV, we must address structural barriers to prevention and care

We have the tools to end AIDS in North America. HIV infection can be effectively managed with combination antiretroviral therapy, and exciting new research shows that successful therapy also dramatically reduces ongoing HIV transmission. ((NIAID, 2011) Yet in the U.S. and Canada there has been no significant decline in the number of new HIV infections and large numbers of HIV positive persons remain outside of care. In the U.S., over 20% of HIV-positive persons are unaware they are infected, nearly half of all persons who have tested positive for HIV are not engaged in regular care, and only 19% of Americans living with HIV have a viral load that has been driven to undetectable levels by combination therapy. (Gardner, et al. 2011) In Canada, where people with HIV have access to publicly funded health care including HIV medications, there has still been no appreciable effect on the number of new diagnoses each year, and a significant proportion of people with HIV are not in care. (PHAC, 2010)

These facts highlight the limited success of conventional HIV interventions that seek to influence knowledge, attitudes and behaviors, and underscore the need to intervene to influence social or "structural" determinants of health that perpetuate inequities. (CDC, 2010) Progress in reducing HIV-related morbidity and mortality will require structural approaches – policies or programs that

aim to change the conditions in which people live –applied in combination with individual behavioral or medical interventions. As Dr. Kevin Fenton of the CDC recently observed, "We need to address larger environmental issues, such as poverty, homelessness and substance abuse, which are well beyond the traditional scope of HIV intervention. Addressing those is as essential to HIV prevention as providing condoms." (LA Times, 2010)

Housing status is a key social determinant of HIV health outcomes, and one that is amenable to intervention. (Auerbach, 2010; Gupta, et al., 2008) A substantial body of research supports the need for urgent action to address the unmet housing needs of North Americans living with HIV and those most at risk for acquiring HIV infection. "Structural factors can be influenced but until they are, individuals in many settings will find it difficult to reduce their risk and vulnerability." (Gupta, et al., 2008)

HOUSING IS HIV PREVENTION AND CARE

Housing assistance is an effective HIV health care intervention. Consistent findings show that an increase in housing stability is significantly associated with better health-related outcomes in studies examining housing status and HIV transmission, risk behaviors, medication adherence, and utilization of health and social services. (Leaver, et al., 2007; Wilson, et al. 2011; Marshall, 2011)

Housing is HIV medical care

Receipt of housing assistance is among the strongest predictors of accessing HIV primary care, maintaining continuous care, receiving care that meets clinical practice standards, and entry into HIV care among those outside or marginal to the health care system. (Aidala, et al., 2007) Homeless persons with HIV who received a housing placement were twice as likely to achieve an undetectable viral load as a matched comparison group that remained homeless. (Buchanan, et al. 2009) Injection drug users with stable housing were 1.5 times more likely to access highly active antiretroviral therapy (HAART) than those who lacked stable housing, and among IDUs on treatment, those with stable housing were almost 3.7 times more likely to achieve viral suppression. (Knowlton, 2008) In fact, housing status is a more significant predictor of health outcomes than individual characteristics such as demographics, drug and alcohol use, and receipt of social services. (Kidder, et al. 2007; Aidala, et al., 2007)

Stable housing also appears to improve survival. The San Francisco Department of Public Health compared mortality over a five-year period for homeless people with AIDS who received supportive housing through the Department's Direct Access to Housing (DAH) program (n=70) and those who did not (n=606). There were two deaths among persons who received DAH supportive housing, and 219 deaths among those who were not housed. After adjusting for potentially confounding variables, supportive housing was independently associated with an 80% reduction in mortality. (Schwartz, et al., 2009)

Housing assistance improves health regardless of co-occurring behavioral health issues. Low-threshold, harm reduction housing interventions have repeatedly been shown to enable vulnerable persons to establish stability, improve health outcomes, and reduce risk behaviors, especially when coupled with on-site supports. (Wolitski, 2010; Larimer, 2009; Sadowski, 2009)

In fact, housing status is perhaps the most important factor in determining an HIV-positive person's access to health care, their health outcomes, and how long they will live. A recent study by Riley, et al., which empirically ranked factors that affected the health status of HIV-infected homeless and unstably housed women, found that unmet subsistence needs (i.e., food, hygiene, shelter) had the strongest effect on overall physical and mental health. In this population, an inability to meet basic subsistence needs had at least as much effect on overall health as adherence to antiretroviral

therapy, suggesting that "advances in HIV medicine will not fully benefit indigent women until their subsistence needs are met." (Riley, et al., 2011)

Housing is HIV prevention

Housing status also independently predicts behaviors that transmit HIV, after adjusting for other factors that influence risk such as substance use, mental health issues and access to services. (Kidder, et al., 2008; Aidala, et al., 2005). Among extremely low-income HIV-positive persons coping with multiple behavioral issues, those who are homeless or unstably housed are two to six times more likely to use hard drugs, share needles or exchange sex than stably housed persons with the same personal and service use characteristics. (Aidala, et al., 2005) Data gathered by the CDC from 8,075 persons with HIV show that, compared to stably housed persons with HIV and controlling for other factors, persons with HIV who lack stable housing are: 2.9 times more likely to engage in sex exchange; 2 times more likely to have unprotected sex with an unknown status partner; 2.3 times more likely to use drugs; and 2.75 times more likely to inject drugs. (Kidder, et al., 2008)

Housing instability itself appears to magnify HIV risk for vulnerable populations. Female transgender youth in Chicago and Los Angeles with a history of homelessness were 4.4 times more likely to have engaged in sex work. (Wilson, et al., 2009) A large study of homeless men found that HIV risk was directly related to the severity of housing need, with sexual risk behavior more frequent among those who were living on the street or in an abandoned building. (Stein, 2009) A review of the literature shows that housing status is consistently associated with sexual- and injecting-related HIV risk behaviors among persons who inject drugs: injection drug users who are homeless and unstably houses have higher rates of HIV infection and increased risk of HIV seroconversion. (Marshall, 2011) Homelessness plays an important role in the transmission of HIV and sexually transmitted diseases among street-involved youth, and is associated with significantly lower levels of condom use and greater numbers of sexual partners. (Marshall, 2009)

Housing instability is a barrier to reducing HIV risk. Counseling, needle exchange and other proven HIV prevention interventions are less effective among people who are homeless or unstably housed than among those who are housed. Unstably housed needle exchange participants are twice as likely to report high-risk receptive needle sharing than stably housed participants. (Des Jarlais, et al., 2007) Female drug users with unstable housing conditions report higher levels of HIV drug and sex-related HIV risk behavior than their housed counterparts, and their levels of behavioral change over time are lower. (Elifson, et al., 2007)

For homeless and unstably housed persons, housing is a proven HIV prevention intervention. Persons who improve their housing status reduce risk behaviors by as much as half, while persons whose housing status worsens are as much as four times as likely to engage in behaviors that can transmit HIV. (Aidala, 2005) Indigent women with a federal housing voucher were only half as likely to engage in risky sexual behaviors as a matched group of homeless women – in part because housing appeared to protect against victimization by physical violence. (Wenzel, 2007) Perhaps most importantly, housing assistance improves access and adherence to antiretroviral medications, which lowers viral load and can reduce the risk of transmission to a partner by as much as 96%. (NIAID, 2011)

Housing interventions improve health outcomes and cut costs

Two random controlled trials – the first of their kind to examine housing as an independent determinant of health – have linked housing assistance to improved health outcomes for homeless and unstably housed persons living with HIV and other chronic health conditions, and to sharp reductions in avoidable health care costs:

- The Housing and Health (H&H) Study, conducted by the U.S. Centers for Disease Control and Prevention (CDC) and the HUD Housing Opportunities for People with AIDS (HOPWA) program, assessed the impact of immediate access to HOPWA housing vouchers on the physical health, mental health and HIV risk behaviors of homeless and unstably housed people living with HIV/AIDS. The study included 630 HIV-positive participants in three cities – Baltimore, Chicago and Los Angeles, between 2006-2008. At the end of the 18-month study period, only 18% of participants who got study vouchers remained homeless or unstably housed, compared to 49% of the comparison group. Despite high levels of baseline connection to case management (93%) and regular health care (85%), health outcomes improved dramatically with housing stability – including a 35% reduction in emergency room visits, a 57% reduction in the number of hospitalizations, and significantly improved mental health status.[8] Even stronger differences were found in analyses that compared study participants who experienced homelessness during the follow-up period with those who did not. After controlling for socio-demographic variables, substance use, and physical and mental health status, those who experienced homelessness were 2.5 times more likely to use an emergency room, 2.8 more likely to have a detectible viral load at follow up, reported significantly higher levels of perceived stress, and were more likely to report unprotected sex with a negative/unknown status partner. (Wolitski, et al., 2010)

- In an 18-month randomized controlled trial, the Chicago Housing for Health Partnership (CHHP) – an integrated system of housing and supports for individuals with chronic medical illnesses who are homeless upon discharge from hospitalization – compared hospitalizations, hospital days, and emergency department visits among housed participants and a comparison group of chronically ill homeless persons who continued to receive "usual care" (i.e., emergency shelters, family and recovery programs). Among the one-third of CHHP study participants living with HIV/AIDS, those who received housing upon discharge from the hospital were almost twice as likely at 12 months to have an undetectable HIV viral load compared to HIV-positive participants randomly assigned to "usual care." (Buchanan, et al. 2009) Overall, CHHP participants were three times more likely to achieve stable housing at 18 months than the usual care group (66% vs. 21%), with significantly fewer housing changes (2 vs. 3). This stability translated into significantly improved health outcomes. Controlling for a range of individual and service variables, housed participants had 29% fewer hospitalizations, 29% fewer hospital days, and 24% fewer emergency department visits than their "usual care" counterparts. (Sadowski, et al., 2009)

HOUSING IS AN EFFECTIVE COST CONTAINMENT STRATEGY

Housing assistance for people living with HIV and other chronic illnesses not only improves health but is also a key cost containment strategy. People coping with homelessness are frequent users of expensive crisis services including shelters, jails, and avoidable emergency and hospital care. (City of Toronto, 2006; Flaming, 2009). For the chronically ill, many with co-occurring conditions, housing instability translates into poor health outcomes, inappropriate health care utilization and mounting public costs.

Improved housing stability reduces public costs

CHHP cost analyses show that improved housing stability for chronically ill persons reduces emergency, inpatient and nursing home care costs by amounts that more than offset the costs of the housing intervention. Compared to "usual care," the CHHP housing program generated average annual net public cost savings of over $6,000 per person. (Basu, et al., 2011) Evaluation of a Seattle

[8] Over 50% of "usual care" comparison group members secured stable housing during the 18-month study period. This "cross-over" limited the ability to identify significant differences between the intervention and control groups. However, as housing stability improved for the group as a whole, so did health outcomes.

program for homeless people with chronic alcohol addiction showed that a "Housing First" supportive housing model created stability and reduced alcohol consumption, and decreased health costs (53%), sobering center use (87%) and county jail bookings (45%) compared to a matched group who remained homeless. (Larimer, 2009) The Toronto Streets to Homes Post-Occupancy study found that housing with appropriate supports not only improved quality of life for formerly homeless individuals but also resulted in significant reductions in the use of costly emergency, health and justice services. (City of Toronto, 2006) A large-scale study commissioned by the Los Angeles Homeless Services Authority examined a wide range of public costs among 10,193 homeless persons in Los Angeles County, including 1,007 who were able to exit homelessness via supportive housing. The average public costs for impaired homeless adults decreased 79% when they were placed in supportive housing. Most savings in public costs came from reductions in outlays for avoidable crisis health services, with the greatest average cost savings realized among persons with HIV/AIDS who moved from homelessness into housing. (Flaming, 2009)

These analyses demonstrate the cost effectiveness of housing assistance for persons with chronic illness even before taking into account the costs of HIV treatment failure and heightened HIV risk among people who are homeless. Each new HIV infection prevented through increased housing stability saves over $300,000 in lifetime medical costs. (Schackman, 2006)

Housing interventions are good value for money

Groundbreaking H&H Study cost analyses are the first to determine the "cost-utility" of housing as an HIV risk reduction and health care intervention – the measure used by health economists to compare the "value for money" of health care interventions. The cost-utility of the H&H intervention is a function of the cost of the services provided, HIV transmissions averted, medical costs saved, and quality-adjusted life years saved. Findings show that housing is a cost-effective HIV health care intervention, with a cost per quality-adjusted life year (QALY) of $35,000 to $62,000, in the same range as widely accepted health care interventions such as kidney dialysis ($52,000 to $129,000 per QALY) and screening mammography ($57,000 per QALY) – and far less expensive than HIV pre-exposure prophylaxis (PrEP) ($298,000 per QALY). (Holtgrave, 2011; see also Holtgrave, et al., 2007)

New cost findings presented for the first time at the recent 2011 North American Housing and HIV/AIDS Research Summit underscore the cost-effectiveness of housing as HIV health care. A NYC Department of Health and Mental Hygiene study of health utilization among homeless and unstably housed people with HIV found that – although these individuals had good connections to HIV health providers and attended regular primary care visits – 77% had visited an emergency room in the last six months and 56% had an inpatient hospital stay. Researchers concluded that "lack of stable housing may underlie persistent HIV-related health problems" for these individuals. (Towe, 2011)

The ongoing study of people living with HIV enrolled in the San Francisco Department of Public Health "Direct Access to Housing" (DAH) program showed that the housing intervention dramatically reduces avoidable healthcare spending. An analysis of public healthcare utilization by HIV-positive residents (hospital, ER, inpatient, skilled nursing facility) two years before and two years after placement in the DAH low-threshold permanent supportive housing program revealed that the 13% of HIV positive residents who were "high users" (>$50,000/year in healthcare costs) accounted for 73% of total healthcare costs for the group. While use of outpatient services (predominantly primary care) increased after placement in housing, use of expensive institutional care declined significantly. Median healthcare costs for high users dropped from $100K/year per person prior to housing to just $1,819/year per person after placement. Significantly, net healthcare costs dropped dramatically for the group as a whole following entry into supportive housing, with cost reductions among high users of health care generating savings that more than offset housing costs for all HIV-positive residents. (Bamberger, 2011)

USING EVIDENCE TO DRIVE POLICY AND PRACTICE

Housing assistance is a strategic intervention that can reduce health inequities by addressing both HIV/AIDS and other vulnerabilities such as race and gender, extreme poverty, mental illness, chronic drug use, incarceration, and histories of exposure to trauma and violence, as well as homelessness. Moreover, housing assistance decreases health disparities while reducing overall public expense and/or making better use of limited public resources. This evolving body of research on HIV and housing has profound implications for the broader affordable housing and healthcare agendas, paving the way for new housing policies and practices as public health interventions.

Yet at the current time, affordable housing is completely out of reach for many households living with HIV. There is not a single county in the U.S. where a person who on relies on federal disability benefits can afford even a studio apartment. (NLIHC, 2011) Available housing resources can meet only a fraction of actual need. The U.S. federal Housing for Persons with HIV/AIDS (HOPWA) program is funded to serve less than 30% of homeless and unstably housed Americans living with HIV. Despite its position in the world as a developed and wealthy nation, Canada has no coordinated national strategy to ensure access to adequate and affordable housing. In many North American communities HIV-specific housing supports are tied to a diagnosis of advanced HIV disease and/or extreme poverty – which further limits access to housing.

Both the U.S. National HIV/AIDS Strategy and Opening Doors: the Federal Strategic Plan to Prevent and End Homelessness recognize housing as an HIV prevention and care intervention, and call for policies and practices that incorporate housing assistance as a critical component of care. Yet, as noted in the HUD National HIV/AIDS Strategy implementation plan, "the provision of housing has not been clearly understood as a key element in community approaches to HIV prevention and care." Implementation of these two strategies and of the U.S. Affordable Care Act presents a critical opportunity to ensure that HIV-specific housing-based interventions become a core health activity.

Now that we have solid evidence of the effectiveness and cost-utility of housing as an HIV prevention and care intervention, how do we translate this knowledge into public policies and interventions that are scaled to meet real need?

Housing and HIV/AIDS Research Summit participants have identified at least four intermediate goals necessary to bring about the shift to evidence-based HIV housing policy and practice:

Use HIV/AIDS housing research to raise the profile of housing as a public health issue.
"Hard" health care markers like CD4 and viral load have made it possible to rigorously track the health impact of housing interventions, and this research provides critical data to inform the delivery of health services, including initiatives to control the unsustainable growth in health care spending. Many HIV/AIDS housing programs have pioneered innovative approaches to address the co-occurring medical, substance use and mental health needs of the people they serve. Research findings provide important empirical evidence that homeless and unstably housed persons with lifelong chronic care needs, including those who are mentally ill and/or chemically dependent, can achieve better health outcomes if provided with necessary housing and supports.

Communicate the public policy objectives of housing supports across systems.
Current systems for health care, mental health, criminal justice, child welfare, and substance use treatment fail to incorporate housing resources as a key component, and different service systems struggle in isolation to manage high costs and service demands. Progress on structural interventions is limited by the disconnect between those who pay for health care services and those who implement structural interventions that reduce illness. Better budgeting methods are

necessary to measure the fiscal impact of housing interventions, including evaluation metrics that cut across cost centers and take into account the fact that much of the public "savings" from housing investments occur in public health and medical spending. As a recent Institutes of Medicine report on barriers to HIV care observed, "successful management of patients experiencing multiple, interacting conditions requires, in addition to appropriate medical care, the availability of comprehensive and flexible services, such as transportation, medication adherence programs, and dietary and housing assistance, which generally are not reimbursable by health care financing programs." (IOM, 2011)

Support housing assistance as a primary HIV prevention intervention for at-risk groups.
Rates of homelessness are high among persons at greatest risk of HIV infection due to substance use, mental illness, intimate partner violence, and other vulnerabilities. While it is difficult to estimate total housing need among people at risk, at least one-half of homeless persons in any community fall into one or more of these highest-risk categories, and research indicates that the condition of homelessness itself places all persons who lack stable housing at increased risk of HIV infection. To prevent new infections, we should support housing assistance for homeless and unstably housed persons at risk of HIV infection.

Adopt a public health approach that reduces barriers to housing.
Many people living with and at risk of HIV infection and other chronic conditions are barred from housing resources due to stigma, eligibility requirements, and/or the co-occurring issues, such as histories of incarceration and active drug use, that make them most vulnerable. For this subset of homeless persons, providing housing and on-site services without requiring abstinence or treatment is significantly more cost-effective than allowing them to remain homeless. A public health approach would: lift public housing exclusions based on status, such as a history of incarceration or active drug use; promote housing for chronically ill persons regardless of disease stage, active substance use, or minimum income; and ensure the availability of assistance to overcome barriers to housing access and stability, including barriers related to immigration status.

CONCLUSION

Given the weight of the evidence, we must act now to meet the housing needs of persons living with and at high risk of HIV. Access to safe, affordable housing is a moral/human rights issue, a public health imperative and an issue of fiscal responsibility. This is especially true in the case of persons living with HIV. As the U.S. Institutes of Medicine recently noted, "HIV's communicable nature and the very high personal and financial costs associated with each new infection add significant public health and economic components to the considerations of social justice that necessarily accompany policies that affect the provision of HIV care." (IOM 2011)

Current efforts to expand access to health care, to change the individual behaviors that put people at risk of acquiring HIV infection, and to reduce the public and private costs of avoidable crisis care simply will not succeed without stable housing. "Although some individually oriented interventions have shown results in reducing risk behavior, their success is substantially improved when HIV prevention addresses the broader structural factors that shape or constrain individual behavior, such as poverty and wealth, gender, age, policy, and power." (Dean & Fenton, 2010) Summit Series participants call on international, national, state and local policy makers to join with us to promote an evidence-based, public health approach to the housing needs of people living with and at high risk of HIV infection.[9]

[9] Go to http://nationalaidshousing.org/2008/07/endorseconference/ to endorse the *International Declaration on Poverty, Homelessness and HIV/AIDS* developed by a global coalition.

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The OHTN handled Summit VI logistics and hosts the Summit Series website: www.hivhousingsummit.org.

The Impact of Recent HRA/HASA Rental Assistance Policy Changes on New Yorkers Living with HIV/AIDS – Findings from a Survey of Community-Based Case Managers

July 2011

Background:
Tenant based rental assistance is historically – by far – the most significant type of housing assistance provided for poor New Yorkers living with AIDS or other advanced HIV illness. Over 80% of the approximately 32,000 PLWHA who currently rely on public assistance for permanent housing support live independently with the help of rental assistance. Particularly significant is the enhanced rental assistance for persons with HIV/AIDS established in the mid-1980s by New York State regulation. Title 18, Section 397.11 of the codes, rules and regulations of New York State provides for enhanced rental assistance for individuals and families with clinical, symptomatic HIV illness.

In February and March 2011, the NYC Human Resources Administration (HRA) changed its long-standing policies regarding payment of brokers' fees and security deposits on behalf of extremely poor New Yorkers who are eligible for a housing allowance as part of their household's public assistance budget. HRA advances security deposits and pays broker's fees in order to enable eligible persons to use State and City funded rental subsidies to secure apartments in the expensive and highly competitive New York City private rental market. Rental assistance and other housing supports for poor New Yorkers living with AIDS or other advanced HIV related illness are administered by HRA's HIV/AIDS Services Administration (HASA), and are therefore subject to the following policy changes:

- HRA/HASA will no longer provide cash security deposits to enable clients to secure apartments. Instead, landlords are offered a voucher that can be submitted at the end of a lease to request compensation for any damages that can be proven by the landlord;
  and
- Broker fees are now limited to an amount equal to half of one month's rent (a 50% reduction from prior policy).

Assessing the impact on households living with HIV/AIDS:
During May 2011 consultants Shubert Botein Policy Associates (SBPA) developed and administered an online survey of NYC case management providers who assist HASA clients to find and secure private market housing. The survey was designed to gather data about how the new HRA policies on security deposits and brokers fees are affecting the ability of NYC households living with HIV/AIDS to secure housing. Respondents were asked to share their experiences with the new policies and those of their clients living with HIV/AIDS, but not to share client names or other identifying information. A link to the survey instrument was distributed widely on May 17th – primarily to COBRA providers across the City. Responses were collected during the 2-week period ending June 1st.

Results:
In just two weeks SBPA collected 238 responses from case managers at 44 different community-based agencies. The majority of responses are from COBRA case management program staff members, but respondents reflect a wide range of medical and supportive services providers who work with PLWHA in all five boroughs of the City – including hospital-based medical case managers, housing placement specialists, discharge planning staff, and other direct service providers.

Respondents report that a significant percentage of their current clients are homeless or unstably housed and actively seeking housing; 63% of respondents report that more than half of their clients are involved in a housing search at any given time.

Survey respondents report that the recent changes in HRA rental assistance policies have significantly affected the PLWHA they serve, with the brokers' fee change being the most damaging.

- Over 95% of clients involved in a housing search have experienced one or both policy changes as a barrier to housing placement;
- 79% of respondents report that the security deposit change poses a significant barrier to their clients;
- 94% report that the brokers' fee change is a significant barrier, with 50% reporting that it has prevented placement for one or more clients;
- 61% of the case managers who responded to the survey report that, compared to this time period last year, it takes significantly longer to find and secure an apartment using the HASA rental assistance program.

Security voucher change:

As one citywide COBRA provider stated: *"Landlords do not want to accept a voucher in lieu of a cash security deposit."*

A Queens case manager explained: *"With security voucher landlords not confident they will get the lost monies due to damages or rent not paid."*

One respondent described a typical incident: *"The Landlord upon hearing about the Security Deposit change unilaterally dissolved the newly signed Lease and refuse to rent the apartment to our client. Instead, the apartment was rented to another individual. HASA refused to intervene regarding the breech of contract involving the dissolution of the lease."*

Brokers fee reduction:

Respondents explained that HASA clients seeking housing are being asked to pay the balance of the broker's fee out of pocket, or are simply refusing to work with clients using a HASA rental assistance voucher:

A COBRA worker from a large community-based organization in lower Manhattan reported, *"When contacting realtors and brokers, I have been informed that they will not assist with HASA clients any longer because they can not depend on the voucher program or only receive half of their normal broker's fee."*

A community follow-up worker from a large citywide organization explained, *"The first question any broker or agency asks is if the client can pay the other half of brokers fee."*

A COBRA case manager from a large Manhattan-based AIDS service organization said, *"Most brokers now make the clients responsible for paying the other half of the broker's fee which is impossible for some clients who don't have any type of income..."*

Another from the same agency reported, *"Clients are unable to obtain brokers assistance in locating housing because many agencies no longer wish to work with the programs."*

A Manhattan-based housing specialist said, *"The majority of brokers that I work with have said that they will no longer offer apartments to clients that have HASA rent subsidies and that most of their landlords are also re-evaluating whether they will accept clients who have a HASA rent subsidy."*

"[One hundred percent] of my clients who are currently seeking housing do not have other sources to fund half of broker fee," reported a case manager from a Manhattan health center.

Another described the overall impact, *"It's discriminatory, since HASA already has stigma associated with it and this just adds to it."*

A case manager who works with clients in Staten Island reported, *"The clients are on limited/fixed incomes and cannot afford to pay towards a Brokers fee. This is causing some clients to do side deals with brokers to secure housing and avoid homelessness."*

A clinical supervisor for case managers in a large community-based health setting described her clients' experiences by saying, *"Many clients are being asked by the broker to come up with the additional money for the brokers fee, which our client cannot afford. This has definitely prevented placement."*

When apartments are lost, respondents report that clients face extended stays in unstable and inappropriate emergency housing:

Client advocacy staff in Manhattan stated, *"I have clients that have had to ask their families for the money to cover the broker's fee and that other half of the deposit. I've had [clients] lose apartment opportunities and have to stay at SROs. Every single apartment possibility has been adversely affected since the implementation of this policy change."*

Another COBRA worker in Manhattan reported, *"My clients are repeatedly viewing HASA approved apts. and are not able to take them because they cannot afford the broker's fee. These clients are living in temporary housing such as SROs and shelters."*

Another case manager explained, *"Many landlords and realtors are sympathetic to our clients needs however they have expressed that they can not absorb the financial burden of not having a security deposit and brokers' who work on commission count on the brokers' fee. The brokers' especially go to bat for clients and make landlords who are skeptical or ill informed about HASA consent to have clients. Without their support many clients will not find housing. Also they expressed their dismay at the way the decision was unveiled. It was quietly announced mere weeks or days before March 1st."*

A case manager in an adult day health program said, *"My clients end up being stuck in SRO after SRO because they can't find an apartment and congregate facilities are full as well because of this change in policy."* This case manager continued to describe, *"Landlords and brokers are expecting clients to come up with the difference, which, as I understand it, could jeopardize the clients' HASA benefits, even if such a thing weren't completely cost prohibitive. But we have clients considering borrowing money from loan sharks or selling drugs in order to come up with the difference, hoping they can convince the broker and/or landlord to alter the paperwork so HASA doesn't find out."*

A supportive services supervisor described the lengths clients were going to in order to raise the additional half of the brokers' fee. *"The clients of the Supportive Service Programs are all men who have sex with men (MSM)/gay men of color. They are often younger clients without means of coming up with the other half of the broker's fee (usually $550). Many of our clients have histories of survival and commercial sex work. Since housing is a priority for them many resort back to prostitution to earn the other half of the brokers' fee... Clients are also staying longer in SRO's, for younger clients who are gay or transgender this can create another set of problems for safety especially if they are young."*

Implications:
While the recent changes to rental assistance policy were put forward as a "budget cutting" measure, survey results indicate that the net effect of these changes will be greater hardship for PLWHA seeking housing, longer stays by HASA clients in institutional settings and expensive and dangerous emergency housing, and poor health outcomes for individuals and the community.

A COBRA case manager from a large organization working in the Bronx described the impact on their clients by saying, *"With housing availability in the Bronx so limited as it is, this reduction in broker fee makes placement impossible. Our clients will remain in transitional housing longer, remain homeless longer and/or stay in substandard housing for longer. We primarily utilize brokers to locate HASA accepting apartments... Not one of the brokers will accept the 50% payment for their services... They are asking the client to make up the difference from their own finances. Our*

ability to locate housing for any of our [clients] since this change in policy has virtually halted any housing placements. We anticipate a bleak outlook for housing placements in the future if this policy remains." He went on to say, *"In addition we have been informed by several clients that they will resort to loan sharks to make up the difference of the broker fee. This is a dangerous practice."*

The COBRA Program Director at a large city-wide AIDS service organization described a client's lack of ability to secure housing: *"One client in particular had viewed an apartment several months ago but was not approved by HASA due to a window that was not working properly. After several failed attempts at other housing placements, my case manager and client returned... to the same apartment complex to look at another apartment... but now the apartment complex refused to take a HASA security deposit voucher and asked the client to pay the $1,100 security deposit himself. Client does not have the money and is now living in an SRO. This client is on dialysis, has severe [mental health] issues and is an older gentleman."*

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TESTIMONY ON BEHALF OF THE AIDS CENTER OF QUEENS COUNTY: CITY COUNCIL GENERAL WELFARE COMMITTEE OVERSIGHT HEARING ON NEW HASA POLICIES, FEB. 8, 2012, 1:00PM, 250 BROADWAY, 16th Fl.

My name is Harriet Cohen and I am the Director of Housing at the AIDS Center of Queens County (ACQC). ACQC, a 25-year old borough-based organization, provides comprehensive services for People living with HIV/AIDS (PLWHAs) and their partners, families and significant others including: education, prevention and testing; licensed Mental Health services; COBRA Case Management; Harm Reduction and Syringe Exchange; and Housing for people who are homeless or at risk for homelessness because they are living in unstable or unsafe conditions that compromise their medical health.

I manage seven (7) housing programs serving 450+ clients, most of whom are struggling with poverty, mental illness, and histories of substance use and incarceration. Our contracts for scattered site, supportive, transitional, housing placement and stabilization initiatives are funded by the federal Housing Opportunities for People Living with HIV/AIDS (HOPWA); NYC's Human Resource Administration's HIV/AIDS Services Administration (HRA/HASA), NYC's Public Health Solutions, and the New York State AIDS Institute.

Numerous studies have demonstrated that stable housing is the cornerstone of HIV/AIDS treatment, allowing people who are living with HIV/AIDS to access comprehensive healthcare, adhere to complex HIV/AIDS drug therapies, and find an improved quality of life. ACQC's programs aim to achieve these very goals – supporting clients to: access and maintain housing; connect to and remain in care; reduce stress; and work on recovery and rebuilding their lives.

The March 2011 HASA policy that reduced by 50% the broker fee and substituted a redeemable security voucher for an upfront cash deposit has had a profound and negative impact on ACQC's ability to secure housing for our clients. These policies have resulted in: loss of countless broker contacts, landlords no longer willing to house our clients, and much delayed housing access forcing clients to remain longer in their costly and/or untenable accommodations. It has compromised client gains in wellness by adding stress to the housing placement process, causing longer search times and complicating the process required to locate an apartment, sign a lease, get HASA approval and checks cut, retrieve the keys and assist clients with move-in.

Upon learning about the new broker fee/security voucher policy which came to us via the grape-vine and NOT in advance or with any sunlight or decision-making transparency, I asked our Housing Specialists to keep track of broker responses. Within a short period of time 40 brokers dropped out of our partnership network. This network, which was once robust, has diminished significantly. One Housing Specialist reported recently that his broker contacts went from 35 to 7, and has barely improved since last year. It should be noted that many of the brokers we work with in Queens are not licensed themselves, but work in tandem with a broker who is, thereby

already splitting their fee 50-50. With the new HASA policy, they are now receiving 50% of the reduced 50%. This is not an incentive for brokers to work with HASA clients.

Although we rely on brokers, we also work with landlords directly. Many of these own the small buildings that predominate in Queens; sometimes they occupy the other apartment in a 2-family house. These individuals rely on upfront cash for the security deposit, again an inducement to house HASA clients. Importantly, these small owners do not have the kinds of record keeping systems or the ability to produce photographs or estimates of work to be done that are now required to redeem a security deposit when the tenant moves out, but has damaged the apartment or missed rent payments. This new process is a burden for small owners.

Here are some real life examples where we lost apartments due to broker fee cutbacks and the client's health and wellbeing was further compromised:

1. Client MR is a senior citizen who uses a wheel chair and is reliant on her family. She sought an apartment closer to them and her doctors in Ridgewood. The Housing Specialist found the perfect first floor apartment for her in that neighborhood. However, we lost the apartment because the broker refused to rent it without the full fee. We are still working to house this gravely disappointed client.
2. Client LV is an above-the-knee amputee who needed a wheelchair accessible apartment located on the first floor or in an elevator building. He was living in a 2nd floor apartment where he was sliding up and down the stairs on his buttocks. An accessible apartment was identified for the client; however, the realtor would not rent it to him without the full

broker fee. We scrambled to find the funds for the additional 50% so we would not lose this difficult to find apartment, adding considerable time to finalize lease negotiations, not to mention additional anxiety and stress for the client.

3. Client YC resided in a transitional facility when she was referred for permanent housing. An apartment was located for YC, but the broker refused to complete the transaction without the other 50% upfront. The client was informed that we would find another apartment for her. A few days later we were notified by a family member that YC had been assaulted and hospitalized. The broker had contacted the client directly and promised her the apartment if she could pay the full fee. She attempted to earn the extra broker fee through prostitution and was beaten and robbed by the solicitor.
4. Client CG viewed numerous apartments with a Housing Specialist. Most, if not all, required the other 50% of the broker's fee. Because we had lost so many apartments due to the reduced broker fee situation, and for some months had difficulty meeting our monthly performance based apartment placements, ACQC consented to pay a small portion, leaving a small portion for the client. By the time all sources were in place, the apartment was no longer available to us.
5. Several of our clients who have been moved into their permanent apartments report being constantly approached by their landlord for additional security deposit monies. Last month one of our Housing Specialists mediated a situation where the client wanted to file harassment charges against the landlord due to constant requests for more money.
6. In our experience, almost all brokers approach clients directly for the other 50%: either after our staff leaves, or they are phoned directly or taken aside at the apartment showing.

And these are only some examples. I think you can understand that the reduced broker fee and security voucher are negatively impacting the goal of housing stability for HASA clients. We appeal to the General Welfare Committee to work to restore the full broker fee and security deposit so people living with HIV/AIDS can be housed in a manner that is timely and appropriate to their medical condition and homeless status. We believe this is the right and compassionate thing to do.

An important additional comment concerning another recent HASA policy: this one indirectly announced to HASA clients and the provider community on the eve of World AIDS Day in the ***Huffington Post***, NOT exactly a NYC media outlet or sunshine venue. HASA clients with long histories of substance abuse will be referred to a CASAC for assessment and to work on 'their individualized substance treatment needs'. Those who do not participate will: lose their enhanced rental assistance; be denied rent arrears payments; or be referred for scarce supportive housing.

ACQC is an agency whose services are designed to meet clients where they are, assist them to articulate and define their own treatment or wellness plan by prioritizing their most pressing needs. We assist through non-judgmental dialogue and guidance, and strive to create relationships with clients that motivate them to move toward independence and self-sufficiency. HASA's new substance use policy interferes with and is counter to this kind of approach. Enrollment in a Harm Reduction Program, for example, does not qualify as treatment under the new policy. Those of us who work with people who have long substance use histories know that cycling through multiple program and treatment experiences at best only produces short-lived

positive outcomes. While this is not the appropriate forum for critiquing substance use treatment programs, we do know that especially with long-term users, harm reduction that assists clients to decrease their use over time has been shown to produce good results. You cannot 'force' someone into treatment, nor demand a positive outcome. Change requires a ready participant who believes in and wants to make the transformation. HASA's policy is not the way to motivate clients to begin the long road to wellness. We call on the General Welfare Committee to exercise its oversight powers and ensure that HASA reconsiders this ill-advised policy.

Harlem United Community AIDS Center. ksmith@harlemunited.org

Testimony before
The New York City Council
General Welfare Committee

Michael Hester,
Senior Director of Operations

Kimberleigh J. Smith, MPA
Senior Director for State & Local Policy

On behalf of:
Harlem United Community AIDS Center
Steven C. Bussey, Chief Executive Officer

February 8, 2012

Thank you, Councilwoman Palma and members and of the General Welfare Committee, for your attention. My name Michael Hester, and I am the Senior Director of Operations at Harlem United Community AIDS Center. I am joined by my colleague, Kimberleigh J. Smith, the Senior Director for State & Local Policy, as well as a few other staff and clients of Harlem United.

Some of you may be familiar with Harlem United. We have been at the forefront of addressing health disparities by recognizing the need for stable housing and ongoing health care since 1991. Our supportive housing services have specialized in serving those most affected by HIV and AIDS and a majority of these clients are not only diagnosed with HIV or AIDS, but with a multiplicity of co-morbid conditions and issues, among them chronic homelessness, substance abuse disorders, mental illness and extreme poverty.

Individuals in our supportive housing programs are provided a full continuum of medical, mental health and social support services to stabilize health and increase self-sufficiency. With 585 units, Harlem United is one of the largest AIDS supportive housing providers in the city and the country. Forty-nine units are within congregate housing setting and the remainder is scattered-site. These units house nearly 1,000 men, women and children.

HRA and HASA purport to want to move clients toward independence; but their policies – (1) to no longer provide cash security deposits to enable clients to secure apartments and (2) limiting broker's fees to half one-month rent– present a disincentive and an all-out barrier to clients to move toward independence. The consequences of these new policies create potential risks for increased instability and homelessness.

As one of the city's larger housing providers, we have thus far been able to protect our clients from these policies but not without a substantial cost and burden to our organization and our clients. Furthermore, we are not certain how long we can continue to absorb these costs. Consider these implications:

- Harlem United's list of brokers for transitional housing has diminished from 85 to 5 since March, as a result of the policy changes;
- Our remaining brokers are receiving 100% of their fees only because Harlem United is paying the fees out of program contracts and general operating funds
- To date, Harlem United has leased **45** apartments subsidizing broker fees in the amount of **$27,876.70.**
- These are funds that would normally pay for furniture, program supplies, maintenance, salaries, and repairs.
- In addition, bureaucratic delays mean that Harlem United must "front" the reimbursable part of the fees and wait to get paid back. Currently, we've got outstanding fees for **14** units pending; totaling **$8,165.00)**

As I mentioned, it is not yet clear how long we can continue to pick up these costs. We are deeply concerned about the future impact these counterproductive policies will have on our clients. The greatest impact will be on those clients leaving transitional housing and entering in to an independent living situation.

With regard to the security deposits:

- None of our landlords will take the voucher
- Voucher is only good for us anyway as the lease is in Harlem United's name
- Clients living independently are at a disadvantage
- Harlem United is thus far covering the security deposit costs

In order to secure apartments, HU paid **$52,704.94** to cover the security deposit. **Without fronting such expense, HU wouldn't be able to house an additional 45 families.** These monies will not be refunded to Harlem United until the apartment is vacated and in good condition. In the event the apartment has sustained damages due to tenant negligence, the cost is automatically deducted from the security deposit. In order for HU to receive reimbursement, HU must gather the necessary documentation (pictures, bills etc) required by HASA to qualify for a security deposit refund.

We, at Harlem United, share the city's goal of supporting and moving individuals toward independence and stable housing. After all, we know firsthand the role transitional housing plays, typically as an intermediate step, between crisis and stability for our clients. All of our transitional housing clients have experienced extreme poverty and were homeless or inadequately housed prior to placement. Our programming increased number of individuals engaging in school, working and moving further away from the risk associated with homelessness into permanent housing alternatives.[1]

The effectiveness and impact of programs like ours are threatened by these new policies. The "lift" to help clients achieve independence and stability is that much more difficult. We call on you to work with Commissioner Doar, your colleagues on the City Council and the Mayor if necessary to reconsider the limit on broker's fees and the security deposit voucher policy.

Thank you for your time and attention.

[1] These findings from an evaluation of Harlem United's transitional supportive housing programs can be found in the 2010 Harlem United Community AIDS Center Program Evaluation, which is available on request at ksmith@harlemunited.org.

THE PARTNERSHIP FOR THE HOMELESS

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Testimony of
Scott Cotenoff, JD, MPH
Senior VP, Programs & New Initiatives
New York City Council
General Welfare Committee
February 8, 2012

Good Afternoon. My name is Scott Cotenoff, and I am the Senior Vice-President, Programs & New Initiatives for the Partnership for the Homeless. For more than 25 years, the Partnership has been at the forefront of the battle against homelessness in New York City. Through our direct work with tens of thousands of individuals and families experiencing homelessness, including those living with HIV and AIDS, we have gained valuable understanding of those systems and situations that push people from their homes as well as insight into potential solutions for ending the dual crises of HIV/AIDS and homelessness.

We appreciate the opportunity to provide testimony regarding our experience with HASA, and our message today is simple – while an important resource for people living with HIV and AIDS, more transparency and oversight is required of HASA and its operations if we are to truly provide the kinds of supports needed by people addressing the challenges of HIV/AIDS and housing instability.

As an initial point, as you have heard from others, HASA's decision to reduce the fee it pays to brokers for apartments by 50% has had a significant impact on the people we serve. For example, following this policy change, the time it takes us to find housing for our clients has more than doubled – from less than 2 months to more than 5 months. This delay is clearly linked to the reduced number of brokers willing to work with HASA.

In addition, more than 60% of our clients have decided to put their housing search on hold – nearly ¾ of these people currently live in SROs or other form of transitional housing. As a result, not only has this policy change negatively affected the search for permanent housing, but it has also created waiting lists for transitional housing. Finally, nearly 30% of our clients have indicated that they will pay the additional brokers fee themselves. Without being specific about how they intend to secure the additional funds, these individuals have referenced "various ways" to get the money. So, not only has this change in policy created a significant barrier to finding critically important – and in some cases, life saving – permanent housing; but it has also created a situation in which people feel they have no choice but to pursue behaviors that are likely to be detrimental to their physical and emotional health in order to be housed.

As such, the City Council must take the steps necessary to have this policy reversed and to require HASA to pay the full brokers fee for their clients.

The brokers fee issue, however, is merely one of several challenges with HASA that require City Council oversight. There are some fundamental issues regarding the work of HASA that impact the ability of clients to find housing – issues that relate to the basic authority of HASA workers and the level of accountability HASA faces for its decisions.

For PLWHAs in search of decent and affordable housing, HASA's often slow and inconsistent bureaucracy, lack of transparency and virtual absence of accountability are barriers to finding housing. At each step along the process, these barriers either prevent clients from securing the stable housing that is so critical to their health and well-being, or create situations in which our staff must spend considerable time advocating with HASA staff for something that should be well within the clients' rights. As a result, more time is spent on a process that should be – in fact, could be – considerably more efficient.

There are two primary points along someone's interaction with HASA that are of particular concern to the Partnership and which require additional Council oversight – HASA's assessment as to the type of housing to which an individual should be entitled (*e.g.,* independent or supportive); and HASA's determination as to whether a specific apartment is appropriate for rental to a client.

It is clear to us, based on our experience with these assessments, that either there is an absence of consistent regulations, guidelines and training as to how these assessments are conducted or HASA front-line workers act arbitrarily and do not consistently follow whatever regulations or guidelines may exist. When clients are

first assessed, for example, regarding type of housing, there is little if any consideration given to the concept of client choice or the input of others (case managers, social workers) who have a far deeper connection with and understanding of the client's abilities and needs. Decisions on these issues are rarely supported by reasoning, executed without written notice and without the opportunity for any review or appeal.

Similarly, decisions regarding apartment denials are likewise made without consistency. For example, 15% of the apartments that have been requested by our clients have been denied, with "excessive rent" given as the reason when, in fact, the rents are within HASA's stated range. We have had a number of occasions in which an initial apartment request was denied, only to have a subsequent request approved without hesitation when the client finds essentially the exact apartment through a real estate broker identified by the HASA worker. This type of behavior puts the health of individuals at risk, diverts our time/resources from assisting others to advocate on these denials, and raises questions about why the delivery of HASA services appears so arbitrary.

These issues, combined with the reduction in brokers fee payments, have resulted in HASA serving as more of a barrier to overcome than a support to assist PLWHAs looking for housing.

Clearly, more oversight of HASA is needed. In an effort to create some level of transparency, the Partnership has submitted a FOIL request to obtain relevant documents from HASA. I have attached a copy of this request to our testimony. There is also, however, a need for stronger City Council oversight. While Local Law 49 did create certain reporting requirements to the Council, such requirements only pertain to activities (*e.g.*, the number of applications, the number of applicants referred to certain types of housing) and require minimal if any analyses of the impact of their work. A more rigorous analysis of HASA services is needed to ensure that individuals are receiving services appropriate to their circumstances and that policies and procedures are applied consistently across the board.

So, for example, HASA should be required to report the rate at which applicants are deemed suited only for supportive, as opposed to permanent housing, and provide a comparison of this rate to a breakdown of the types of housing sought. They should be required to identify the rate at which they apply certain reasons for housing denial (such as excessive rent or apartment conditions), and compare these denials with any written criteria that exist to define these situations.

These are but a few of the issues we believe require more stringent Council oversight. We would be happy to work with the Council to identify others as appropriate.

Thank you for the opportunity to speak with you this afternoon. We remain available to answer questions and to assist the Council in working to ensure that people facing the dual challenges of HIV/AIDS and housing instability in New York City have the support they need to live full and satisfying lives.

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February 7, 2012

Records Access Officer
Office of Legal Affairs
Human Resources Administration
180 Water Street, 17th Floor
New York, NY 10038

Freedom of Information Law Request

Dear Records Access Officer:

Under the provisions of the New York Freedom of Information Law, Article 6 of the Public Officers Law, I hereby request all records, materials, agreements, reports, memoranda, and any other documents, or portions thereof, pertaining to[1]:

1. The HIV/AIDS Services Administration's (HASA) assessment tools and/or policies for determining what type of housing, *e.g.*, whether independent or supportive, is best suited for a given client, including any consideration of client choice or outside case manager determination;

2. HASA's assessment tools and/or policies for determining whether a given apartment or housing unit is appropriate for rental to a HASA client, including rent guidelines, location requirements, and any other criteria;

3. Any obligation to notify HASA clients in writing of decisions as to the suitability of a given apartment or housing unit for rental to the client;

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[1] **Please Note**: To the extent some documents responsive to my requests are more readily available than others, I would be grateful if you could please send the requested materials on a rolling basis in batches. In other words, I would appreciate getting copies of any documents as they are gathered and do not want to delay my review of them because it may take longer to gather documents responsive to other portions of the request.

4. Any process by which a HASA client can appeal (whether formally or informally, inside the agency or to an external body) the determination as to either (a) the type of housing, *e.g.*, whether independent or supportive, that is best suited for that client or (b) whether a given apartment or housing unit is appropriate for rental to the client;

5. Any educational or training requirements for HASA caseworkers, including any training in methods of determining the housing readiness of individual clients;

6. Lists of apartment brokers and/or landlords routinely or repeatedly used or recommended by HASA caseworkers to individual clients;

7. Any conflict of interest or other guidelines governing the conduct of HASA caseworkers.

I would appreciate it if you could *please provide electronically any documents that are available in electronic format*. If all of the requested records cannot be e-mailed to me, please inform me by e-mail at jinsleypruitt@debevoise.com of any portion that can be e-mailed or provided on DVD/CD. If the records are not available electronically, and there are fees for copying the records requested, please supply the records without informing me if the fees are not in excess of $200. If the costs exceed this amount, please inform me before fulfilling the request.

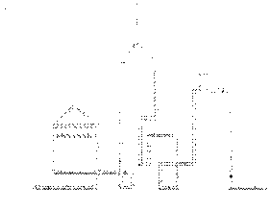
If for any reason any portion of my request is denied, please justify such denial by reference to specific exemptions of the Freedom of Information Law. Please also inform me in writing of the nature of the document(s) withheld, and provide the name and address of the person or body to whom an appeal should be directed. We will expect you to release all segregable portions of otherwise exempt material. We reserve the right to appeal your decision to withhold any information.

If you have any questions about my request or if you would like to discuss means of delivery of the requested information, please feel free to contact me via e-mail (jinsleypruitt@debevoise.com) or telephone (212-909-6246).

I look forward to your prompt reply. Thank you for your assistance.

Best regards,

Jennifer Insley-Pruitt



the Network
Supportive Housing Network of NY

Testimony to the General Welfare Committee on Recent HASA Policy Changes February 8th, 2012

Good afternoon. My name is Edline Jacquet and I am the Policy Analyst at the Supportive Housing Network of New York. The Network represents over 200 nonprofit developers and social service providers who collectively operate over 43,000 supportive housing units throughout New York State, including over 28,000 units in New York City.

Supportive housing is permanent affordable housing linked to onsite services. It is a proven, cost effective, and humane way to provide stable homes for formerly homeless, disabled and low-income individuals and families, including tenants with mental illness, substance abuse, HIV/AIDS and other barriers to independent living. By offering tenants onsite case management services, supportive housing reduces the use of expensive emergency services like shelters, hospitals, prisons, and psychiatric centers.

According to the latest data from the Human Resources Administration (HRA), there are 4,524 HASA clients living in supportive housing in New York City.[1] The case management and other supportive services that HIV/AIDS Services Administration (HASA) clients receive in supportive housing are essential to maintaining their stability which has been shown to dramatically improve health outcomes. Housing is an essential component to individuals living with HIV/AIDS particularly those who are low-income.

My testimony addresses the recent policy changes on brokers' fees and security deposits enacted by HASA and the potential impact of these new policies on the thousands of New Yorkers living with HIV and AIDS who are in need of stable and affordable housing.

Recent Policy Changes

As part of the FY 2011-2012 budgets cuts to several HASA programs by HRA last year, HASA now only pays fifty percent of the brokers' fees and no longer provides an actual cash payment of security deposits but instead now issues vouchers that owners can redeem at the end of a lease to compensate for any damages that can be proven by the landlord. This primarily affects clients who are trying to get out of transitional and emergency housing as well as those trying to move on from supportive housing to a more independent setting. It also adversely impacts the ability of nonprofit supportive housing providers who offer scattered site apartments for HASA clients. Both of these policies, particularly the reduction

[1] New York City Human Resources Administration, HIV/AIDS Administration. HASA Facts, December 2011.

in the brokers' fee have had a negative impact on the ability of HASA clients to find permanent housing. It has made it exponentially more difficult for both clients and supportive housing providers to find and secure apartments. These policies have created barriers to greater independence for HASA clients.

In addition, in a recent blog on the *Huffington Post* on World AIDS Day, HRA Commissioner announced a change in its approach towards drug treatment. In an effort to encourage substance abuse treatment and drug rehabilitation, HASA will no longer offer emergency rental assistance to those who refuse a Certified Alcohol and Substance Abuse Counselor (CASAC) or refuse substance abuse treatment. Clients who do not take this offer have three choices: lose their ability to receive enhanced rental assistance, have their request for emergency rental assistance for arrears denied or be offered a supportive housing placement. Due to the lack of available supportive housing beds for those living with HIV/AIDS, it is unusual that HASA would offer supportive housing for those who may not need or do not want these services. The demand for supportive housing far exceeds the supply and it is unrealistic for HASA to offer this as an option and it frames supportive housing as some type of penalty. This policy also goes against years of research that has shown forced substance treatment does not work. It also does not align with the harm reduction and housing first models that many supportive housing providers now employ in their programs.

Impact of Policy Changes on Individuals Living in Supportive Housing

HASA clients living with HIV/AIDS already face a variety of challenges finding affordable housing. According to the findings in a recent survey of community-based case managers working with HASA clients, 94% of the respondents report that the brokers fee change is significant barrier, with half of them noting that it has prevented placement for one or more clients.[2] In addition, 61% report that it takes significantly longer to find and secure an apartment compared to this previous time period last year. Case managers and providers are all reporting these changes are having a negative impact on a client's ability to find a stable living situation.

Despite HASA's official policy that brokers cannot ask clients to cover the other half of the brokers' fee, they often do and this has resulted in several troubling emerging patterns. HASA clients, who are often desperate to find permanent, affordable apartments, are paying these fees as well as the security deposits themselves. Some borrow money from friends and families but some have also resorted to other more dangerous behaviors like borrowing from loan sharks, selling their medications, going into credit card debt or in some cases prostitution or commercial sex work. This is particularly risky behavior for those in this population but often the only way that clients can obtain the funds they need. In addition these policies could have a broad range of unintended consequences. Historically, it was often difficult for those with HIV/AIDS to locate housing because there was a stigma attached to those living with the disease. These policies could potentially return to those bad old days since many brokers now longer want to serve HASA clients because of the disincentive that has now been created by these policies.

The Impact of These Policies on Supportive Housing Providers

These policy changes have led to have to a substantial reduction in the number of brokers willing to work with supportive housing providers. Many brokers, including those with long

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[2] The Impact of Recent HRA/HASA Rental Assistance Policy Changes on New Yorkers Living with HIV/AIDS – Findings from a Survey of Community-Based Providers. Shubert Botein Policy Associates. July 2011.

relationships with some of our providers will no longer work with HASA clients. Several of the Network's members, such as Harlem United, has seen its list of brokers willing to work with its HASA clients reduced from eighty-five to five. These types of dramatic decreases makes it infinitely harder for providers to locate affordable housing for its clients and increases its costs as clients spend longer periods of times in expensive emergency housing options like shelters, commercial SROs and hotels or institutional settings. Nonprofit supportive housing providers are also being forced to bear the brunt of the costs of these changes at a time when they are already facing growing budget deficits from continual cuts to their budgets. As market rents increase in their scattered site apartments, a growing share of their operations funding is now going towards rents as opposed to supportive services and these policies only exacerbate the problems. To prevent clients, who are often on fixed and very low-incomes form having to pay the brokers fees themselves, our members have been covering these additional costs. This has resulted in significant costs – in one cost, a provider has spent over $40,000 since March 2011 when these policies went into effect. These types of costs are unsustainable over the long-term and create program deficits which inevitably affect services.

HASA should return to its previous policies of providing the full brokers fees and an actual security deposit

HASA has been successful in providing stable, permanent housing and valuable services for thousands of its clients and should continue to use its resources to better serve this vulnerable population. Providing the full brokers' fees and the security deposits allows HASA clients to compete on an even playing field in securing market-rate apartments. Finding an affordable apartment in New York City is a formidable challenge for anyone but even more so for low-income New Yorkers living with HIV/AIDS which represent the vast majority of HASA clients. The Network recommends that HASA discontinue these policies and again provide the full brokers fee and a real security deposit.

Supportive housing has been shown to be an effective model for addressing the varied and complex needs of individuals living with HIV/AIDS. It is critical that the city continue to support the efforts of providing more supportive housing to this vulnerable population. These recent policy changes have led to fewer HASA clients getting placed in both affordable and supportive housing apartments. HASA should return to its previous policies of providing the full brokers fees and security deposits which worked well. While we understand the reality of budget deficits, it should not come at the cost of client stability. Thank you for this opportunity to testify.

Respectfully submitted by:

Edline Jacquet
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The Impact of Recent HRA/HASA Rental Assistance Policy Changes on New Yorkers Living with HIV/AIDS – Findings from a Survey of Community-Based Case Managers

July 2011

Background:
Tenant based rental assistance is historically – by far – the most significant type of housing assistance provided for poor New Yorkers living with AIDS or other advanced HIV illness. Over 80% of the approximately 32,000 PLWHA who currently rely on public assistance for permanent housing support live independently with the help of rental assistance. Particularly significant is the enhanced rental assistance for persons with HIV/AIDS established in the mid-1980s by New York State regulation. Title 18, Section 397.11 of the codes, rules and regulations of New York State provides for enhanced rental assistance for individuals and families with clinical, symptomatic HIV illness.

In February and March 2011, the NYC Human Resources Administration (HRA) changed its long-standing policies regarding payment of brokers' fees and security deposits on behalf of extremely poor New Yorkers who are eligible for a housing allowance as part of their household's public assistance budget. HRA advances security deposits and pays broker's fees in order to enable eligible persons to use State and City funded rental subsidies to secure apartments in the expensive and highly competitive New York City private rental market. Rental assistance and other housing supports for poor New Yorkers living with AIDS or other advanced HIV related illness are administered by HRA's HIV/AIDS Services Administration (HASA), and are therefore subject to the following policy changes:

- HRA/HASA will no longer provide cash security deposits to enable clients to secure apartments. Instead, landlords are offered a voucher that can be submitted at the end of a lease to request compensation for any damages that can be proven by the landlord;
  and
- Broker fees are now limited to an amount equal to half of one month's rent (a 50% reduction from prior policy).

Assessing the impact on households living with HIV/AIDS:
During May 2011 consultants Shubert Botein Policy Associates (SBPA) developed and administered an online survey of NYC case management providers who assist HASA clients to find and secure private market housing. The survey was designed to gather data about how the new HRA policies on security deposits and brokers fees are affecting the ability of NYC households living with HIV/AIDS to secure housing. Respondents were asked to share their experiences with the new policies and those of their clients living with HIV/AIDS, but not to share client names or other identifying information. A link to the survey instrument was distributed widely on May 17th – primarily to COBRA providers across the City. Responses were collected during the 2-week period ending June 1st.

Results:
In just two weeks SBPA collected 238 responses from case managers at 44 different community-based agencies. The majority of responses are from COBRA case management program staff members, but respondents reflect a wide range of medical and supportive services providers who work with PLWHA in all five boroughs of the City – including hospital-based medical case managers, housing placement specialists, discharge planning staff, and other direct service providers.

Respondents report that a significant percentage of their current clients are homeless or unstably housed and actively seeking housing; 63% of respondents report that more than half of their clients are involved in a housing search at any given time.

Survey respondents report that the recent changes in HRA rental assistance policies have significantly affected the PLWHA they serve, with the brokers' fee change being the most damaging.

- Over 95% of clients involved in a housing search have experienced one or both policy changes as a barrier to housing placement;
- 79% of respondents report that the security deposit change poses a significant barrier to their clients;
- 94% report that the brokers' fee change is a significant barrier, with 50% reporting that it has prevented placement for one or more clients;
- 61% of the case managers who responded to the survey report that, compared to this time period last year, it takes significantly longer to find and secure an apartment using the HASA rental assistance program.

Security voucher change:

As one citywide COBRA provider stated: *"Landlords do not want to accept a voucher in lieu of a cash security deposit."*

A Queens case manager explained*: "With security voucher landlords not confident they will get the lost monies due to damages or rent not paid."*

One respondent described a typical incident: *"The Landlord upon hearing about the Security Deposit change unilaterally dissolved the newly signed Lease and refuse to rent the apartment to our client. Instead, the apartment was rented to another individual. HASA refused to intervene regarding the breech of contract involving the dissolution of the lease."*

Brokers fee reduction:

Respondents explained that HASA clients seeking housing are being asked to pay the balance of the broker's fee out of pocket, or are simply refusing to work with clients using a HASA rental assistance voucher:

A COBRA worker from a large community-based organization in lower Manhattan reported, *"When contacting realtors and brokers, I have been informed that they will not assist with HASA clients any longer because they can not depend on the voucher program or only receive half of their normal broker's fee."*

A community follow-up worker from a large citywide organization explained, *"The first question any broker or agency asks is if the client can pay the other half of brokers fee."*

A COBRA case manager from a large Manhattan-based AIDS service organization said, *"Most brokers now make the clients responsible for paying the other half of the broker's fee which is impossible for some clients who don't have any type of income..."*

Another from the same agency reported, *"Clients are unable to obtain brokers assistance in locating housing because many agencies no longer wish to work with the programs."*

A Manhattan-based housing specialist said, *"The majority of brokers that I work with have said that they will no longer offer apartments to clients that have HASA rent subsidies and that most of their landlords are also re-evaluating whether they will accept clients who have a HASA rent subsidy."*

"[One hundred percent] of my clients who are currently seeking housing do not have other sources to fund half of broker fee," reported a case manager from a Manhattan health center.

Another described the overall impact, *"It's discriminatory, since HASA already has stigma associated with it and this just adds to it."*

A case manager who works with clients in Staten Island reported, *"The clients are on limited/fixed incomes and cannot afford to pay towards a Brokers fee. This is causing some clients to do side deals with brokers to secure housing and avoid homelessness."*

A clinical supervisor for case managers in a large community-based health setting described her clients' experiences by saying, *"Many clients are being asked by the broker to come up with the additional money for the brokers fee, which our client cannot afford. This has definitely prevented placement."*

When apartments are lost, respondents report that clients face extended stays in unstable and inappropriate emergency housing:

Client advocacy staff in Manhattan stated, *"I have clients that have had to ask their families for the money to cover the broker's fee and that other half of the deposit. I've had [clients] lose apartment opportunities and have to stay at SROs. Every single apartment possibility has been adversely affected since the implementation of this policy change."*

Another COBRA worker in Manhattan reported, *"My clients are repeatedly viewing HASA approved apts. and are not able to take them because they cannot afford the broker's fee. These clients are living in temporary housing such as SROs and shelters."*

Another case manager explained, *"Many landlords and realtors are sympathetic to our clients needs however they have expressed that they can not absorb the financial burden of not having a security deposit and brokers' who work on commission count on the brokers' fee. The brokers' especially go to bat for clients and make landlords who are skeptical or ill informed about HASA consent to have clients. Without their support many clients will not find housing. Also they expressed their dismay at the way the decision was unveiled. It was quietly announced mere weeks or days before March 1st."*

A case manager in an adult day health program said, *"My clients end up being stuck in SRO after SRO because they can't find an apartment and congregate facilities are full as well because of this change in policy."* This case manager continued to describe, *"Landlords and brokers are expecting clients to come up with the difference, which, as I understand it, could jeopardize the clients' HASA benefits, even if such a thing weren't completely cost prohibitive. But we have clients considering borrowing money from loan sharks or selling drugs in order to come up with the difference, hoping they can convince the broker and/or landlord to alter the paperwork so HASA doesn't find out."*

A supportive services supervisor described the lengths clients were going to in order to raise the additional half of the brokers' fee. *"The clients of the Supportive Service Programs are all men who have sex with men (MSM)/gay men of color. They are often younger clients without means of coming up with the other half of the broker's fee (usually $550). Many of our clients have histories of survival and commercial sex work. Since housing is a priority for them many resort back to prostitution to earn the other half of the brokers' fee... Clients are also staying longer in SRO's, for younger clients who are gay or transgender this can create another set of problems for safety especially if they are young."*

Implications:

While the recent changes to rental assistance policy were put forward as a "budget cutting" measure, survey results indicate that the net effect of these changes will be greater hardship for PLWHA seeking housing, longer stays by HASA clients in institutional settings and expensive and dangerous emergency housing, and poor health outcomes for individuals and the community.

A COBRA case manager from a large organization working in the Bronx described the impact on their clients by saying, *"With housing availability in the Bronx so limited as it is, this reduction in broker fee makes placement impossible. Our clients will remain in transitional housing longer, remain homeless longer and/or stay in substandard housing for longer. We primarily utilize brokers to locate HASA accepting apartments... Not one of the brokers will accept the 50% payment for their services... They are asking the client to make up the difference from their own finances. Our*

ability to locate housing for any of our [clients] since this change in policy has virtually halted any housing placements. We anticipate a bleak outlook for housing placements in the future if this policy remains." He went on to say, *"In addition we have been informed by several clients that they will resort to loan sharks to make up the difference of the broker fee. This is a dangerous practice."*

The COBRA Program Director at a large city-wide AIDS service organization described a client's lack of ability to secure housing: *"One client in particular had viewed an apartment several months ago but was not approved by HASA due to a window that was not working properly. After several failed attempts at other housing placements, my case manager and client returned... to the same apartment complex to look at another apartment... but now the apartment complex refused to take a HASA security deposit voucher and asked the client to pay the $1,100 security deposit himself. Client does not have the money and is now living in an SRO. This client is on dialysis, has severe [mental health] issues and is an older gentleman."*

Testimony before
The Council of the City of New York
Committee on General Welfare

Oversight Hearing: Recent Policy Changes at HASA

February 8, 2012

Kendall Lynnette M. Moses
Housing Project Coordinator
HIV Law Project
15 Maiden Lane, 18th Fl.
New York, NY 10038
212.577.3001

Chairman Palma and Members of the Committee on General Welfare:

I am the Housing Project Coordinator at HIV Law Project. HIV Law Project fights for the rights of the most under-served people living with HIV/AIDS (PLWHA) through innovative legal services and advocacy programs. HIV Law Project believes that all people deserve the same rights, including the right to live with dignity and respect, the right to be treated as equal members of society, and the right to have their basic human needs fulfilled. These fundamental rights are elusive for many people living with HIV/AIDS. For many of our clients, the work of obtaining and maintaining affordable housing is like trying to push a boulder up a hill. The latest policy changes by HASA: the reduction in payment of brokers' fees, the security deposit voucher system, and the substance use screening polices, have turned that hill into a mountain.

As of last March, HASA now pays only 50% of brokers' fees on behalf of clients securing new housing. The vast majority of brokers are unwilling to accept this reduced fee, and have either stopped working with HASA clients, or have informally asked HASA clients to pay the other 50% themselves. This shift has made it nearly impossible for HASA clients and their advocates to secure new apartments, and has forced many PLWHA to spend long periods of time living in single room occupancies (S.R.O.s), which are both unhealthy and unduly expensive. Further, it has forced many HASA clients to take undue and unhealthy risks to secure money to pay a broker.

Brokers play an essential role in placing HASA clients in housing. Cutting their fee by 50% has meant that very few of those brokers who once worked with HASA clients will do so now. But HASA and its clients rely on brokers not just to show apartments, but also to serve as an intermediary between client and landlord, especially with landlords inexperienced in renting to HASA clients. Without brokers to provide that critical level of reassurance to new landlords, the stigma and discrimination so many HASA clients face in their housing search goes unmanaged.

And landlords now have further reason to be wary of renting to HASA clients. New HRA policy now requires HASA to pay landlords their security deposit in the form of a voucher, rather than a check. In order for landlords to collect on this voucher, they must submit extensive paperwork: documentation of damages, estimates for repair work, and receipts for work done. The prospect of such an onerous process is daunting, and disincentivizes landlords from accepting HASA clients. While the city's attempt to control the loss of un-returned security deposits is understandable, the process that has been established is too burdensome on landlords, and must be revised to ensure that landlords will continue to work with HASA.

Though these new policies were adopted as cost-saving measures, an honest assessment of the new reality shows that in fact they have had an unintended, and costly, impact. The lack of brokers willing to accept just half of their fee, and the disinterest of landlords in accepting the security voucher has left our clients seeking permanent housing with very few options. As a result, many HASA clients are stuck in emergency housing. This is both inefficient and unhealthy. The city pays approximately $55.00 per night for emergency housing at an SRO. That amounts to $1,650.00 per month. By comparison, HASA will pay up to $940 per month for a one bedroom apartment. The math just does not add up.

And the conditions in emergency housing are entirely unsuitable for PLWHA. HASA clients in these facilities are regularly without a proper place to cook a meal, or store medications that need refrigeration. While staying in emergency housing, HASA clients are at risk of compromising their sobriety and struggle to maintain their medical, psychological and social service routines. Or they accede to the below-the-radar demands of many brokers that HASA clients now pay the remaining 50% of the broker's fee themselves. In order to do so, individuals are taking dangerous risks: selling their medications, engaging in sex work, and turning to loan sharks in order to come up with the money. Forcing PLWHA to make these sorts of desperate and hazardous decisions is inexcusable.

I'd also like to address HASA's new policy of substance use screening, which further complicates the search for, or the maintenance of permanent housing. While we don't object to substance use screening, *per se*, we do object to the implications and the application of this new policy. First, the policy implies that clients are in arrears solely because they are buying drugs. Yet most people who owe rent arrears are underwater not because of problems with substance use, but because they are forced to pay an undue share of their monthly income to rent. They are in arrears because HASA is the only city agency that does not have a 30% of income rent cap. Many HASA clients receive SSI or SSDI and are forced to spend all but about $360.00 of their Social Security Check on rent. That leaves the client with $12 dollars a day for groceries, utilities, transportation to doctor appointments or treatments, etc. (I cannot tell you how many times clients have told me that they chose to pay ConEd instead of paying their rent.) So passage of the 30% rent cap bill is an essential piece to solving this equation.

Second, the substance use screening not only impugns our clients' dignity, it too is wasteful and inefficient. HASA case managers have full discretion to require substance use screening as a prerequisite to the payment of rental arrears assistance, or the maintenance of ongoing rental assistance. Under the policy, clients who refuse substance-related services, or who are non-compliant with services, can either a) take a supportive housing placement, or b) face eviction and homelessness by losing their right to arrears payments, or above-enhanced rental payments (which are at the city's sole discretion). This is a fictitious choice, since we know that there is a dire lack of supportive housing spots available, due in large part to HASA's delay in developing those units planned under NY/NY III. This is a further example of a choice made under the guise of cost-saving-- saving operating costs-- that quickly becomes a source of additional expenses.

Third, the policy is unduly coercive, and offers an inadequate array of referral options. While New York has long embraced the merits and efficacy of harm reduction services, the available referrals are all abstinence-based programs. HRA should add harm reduction services to the list of available referrals.

Finally, this policy places our clients in jeopardy of losing their Medicaid if they refuse services or are non-compliant with a referral. Once a client's HASA rental assistance case is closed, all other services are stopped and clients must apply separately for food stamps and Medicaid. The only local stand-alone food stamps office is located in Brooklyn, meaning that a physically

disabled client will be forced to travel from her home in the Bronx to Brooklyn in order to re-apply.

In conclusion, these new policies are not cost-saving, as advertised, but the opposite. Meanwhile, they serve as significant hurdles to HASA clients as they attempt to obtain and maintain permanent housing. HIV/AIDS stigma still exists and our clients already face more than enough related challenges. HASA should not add to their burden with these costly, ineffective policies.

I thank you for your attention to this important issue, and for the opportunity to provide testimony.

GMHC

FIGHT AIDS. LOVE LIFE.

February 8, 2012

Testimony to New York City Council
Recent Changes to HASA Policy
Lyndel Urbano, Manager of Government Relation, Gay Men's Health Crisis
Angel Soto, Client Advocate, Gay Men's Health Crisis

Thank you for this opportunity to testify today. We are here today to speak on behalf of Gay Men's Health Crisis (GMHC) and the over 11,000 clients we serve every year. We are particularly concerned about recent policy changes at the Human Resources Administration (HRA) that are adversely affecting people living with HIV. The policy changes at HRA are making it harder for people living with AIDS to find and keep housing, and in some instances they threaten to take away the very support that can address contributing factors to homelessness such as substance use.

Despite New York City's long history of leading the way in confronting the HIV epidemic by working together with communities, these changes to HRA housing policies were made without any consultation, just like attempts by the Mayor's Administration to slash essential HIV AIDS Services Administration (HASA) funding, and the effects have been immediate.

The policy changes mean that HRA only pays 50% of the fee brokers charge to find apartments, and landlords are being asked to accept a voucher in lieu of cash for security deposits. As you can imagine, with New York City's competitive rental market, brokers and landlords are even less inclined to work with HRA and in particular HASA clients. Landlords are suspicious that the vouchers will not be honored at the end of the rental and worry that the validation process to be compensated will be difficult or complicated. To make matters worse, HASA, for all the good work it does connecting clients with resources, has unfortunately developed a reputation among some landlords as a city agency that does not pay its bills on time. In short, the policy changes have exacerbated a problem that is all too familiar to clients; more and more landlords are declining to rent to HRA clients as a business decision.

For our clients the insecurity created by these policy changes leads to stress which adversely affects their illness and in concrete terms they have a much harder time finding suitable housing. Many clients, desperate to leave substandard temporary housing provided in shelters and single resident occupancy units, are being asked to come up with the other half of the fee to pay for the brokers or/and to pay deposits. Some lost apartments they had pre-arranged when the policy went into place. Others are making the extremely difficult decisions to sacrifice scarce resources that would otherwise pay for food,

prescription drug copayments and other essentials. Still others have had to put their health at risk by skipping and selling their medication, or take loans from loan sharks, simply to scrap together enough for a deposit or broker's fee. Remember these are people who are on very limited budgets. The policy also creates a rift between HASA and the people the agency serves. We have heard from clients who are afraid to let their HASA case managers know that they have been required by a broker or landlord to pay the broker's fee or deposit. They think that HASA will in turn reassess their budgets and recoup the funds, since to pay the fee they would have needed additional income.

On top of these changes, HASA has implemented a policy to refer clients they suspect of having a substance use problem to a Certified Alcohol and Substance Abuse Counselor (CASAC). Clients who refuse to follow the abstinence based treatment guidance of the CASAC could lose the ability to receive above-enhanced rental assistance that makes it possible to afford an apartment in New York City. In the words of Commissioner Doar, when he first announced the policy in the *Huffington Post* on World AIDS Day 2011, "HASA clients who choose to not participate in substance abuse treatment based on an assessment's recommendation are faced with a choice: they will be offered supportive housing placement, or they could lose the ability to receive above-enhanced rental assistance or be denied their request for rent arrears payments. This will stay in effect until proof of substance abuse treatment is established."[1]

It is our opinion that there is no scientific or ethical basis to coerce a person into abstinence based substance abuse treatment with the threat of putting them out of their homes or of withholding housing payments.[2] Studies show that stable housing for substance users increases their adherence to treatment and improves treatment outcomes.[3,4] Additionally, we question the wisdom of this strong-armed policy when there is already inadequate supportive housing and the Mayor is attempting to make a permanent $5.1 million funding cut for supportive housing case management and contracts that City Council has restored with one-time restorations.[5,6]

GMHC thanks City Council for its persistent support and respectfully requests close examination of these, at best, problematic policies. It is our respectful opinion that these policies are detrimental to the health and well-being of people living with HIV/AIDS and we urge prompt action to change them.

For more information please contact, Lyndel Urbano, Manager of Government Relations, Public Policy at GMHC: lyndelu@gmhc.org or 212-367-1456.

[1] Doar, Robert. "World AIDS Day 2011: New York's Continued Battle." *Huffington Post* (11/30/11) http://www.huffingtonpost.com/robert-doar/world-aids-day_b_1121846.html Accessed: Feb. 7,2012

[2] Miller, William, R. "Enhancing Motivation for Change in Substance Abuse Treatment: Treatment Improvement Protocol (TIP) Series 35." United States Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Ceter for Substance Abuse Treatment. http://www.adp.ca.gov/SBI/pdfs/TIP_35.pdf Accessed: Feb. 7,2012

[3] Drug Interventions Programme. "Tacking Drugs Changing Lives: Housing Drug Users." (2008) http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/dip-housing-december-08.pdf Accessed: Feb. 7,2012

[4] National Public Radio. "Recovering Substance Abusers, Who Needs Housing, Housing First." NPR News. http://www.npr.org/news/specials/housingfirst/whoneeds/substanceabuse.html Accessed: Feb. 7,2012

[5] There have been no new supportive housing initiatives for HASA except for NY NYIII in the last 5 years. Also in successive budgets, including the Mayor's FY2013 budget proposal, implementation of NY NY III housing for HASA has been delayed. NY NY III housing though other city agencies has been developed much more quickly.

[6] Restorations in different amounts were made by City Council in FY 2010, FY 2011 and FY2012.

THE LEGAL AID SOCIETY

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Testimony to the
New York City Council
General Welfare Committee
on Policy Changes at
HIV/AIDS Services Administration (HASA)

February 8, 2012
250 Broadway, New York, NY

Good Afternoon. My name is Helene Busby; I am a staff attorney at The Legal Aid Society's Civil Practice HIV/AIDS Representation Project. I appreciate the opportunity today to address our concerns about The HIV/AIDS Services Administration's (HASA) new policy regarding mandatory drug screening for HASA recipients. This new policy will result in increased evictions of our medically vulnerable clients from decent affordable housing. Additionally, we wish to submit our concerns regarding recent Human Resources Administrative (HRA) policy changes related to payment of broker's fees and security deposits for public assistance recipients moving into new apartments. These new policies deter landlords and brokers from working with low-income New Yorkers seeking decent affordable permanent housing.

The Legal Aid Society is the nation's oldest and largest not-for-profit legal services organization. It is more than a law firm for clients who cannot afford to pay for counsel. The Legal Aid Society is an indispensable component of the legal, social and economic fabric of New York City – passionately advocating for low-income individuals and families across a variety of civil, criminal and juvenile rights matters, while also fighting for legal reform. The Legal Aid Society has performed this role in City, State and federal courts since 1876. It does so by capitalizing on the diverse expertise, experience, and capabilities of 900 of the brightest legal minds. These 900 Legal Aid Society lawyers work with 600 social workers, investigators, paralegals and support and administrative staff. Through a network of borough, neighborhood, and courthouse offices in 25 locations in New York City, the Society provides comprehensive legal services in all five boroughs of New York City for clients who cannot afford to pay for private counsel.

The Society's legal program operates three major practices — Civil, Criminal and Juvenile Rights — and receives volunteer help from law firms, corporate law departments and expert consultants that is coordinated by the Society's Pro Bono program. With its annual caseload of more than 300,000 legal matters, The Legal Aid Society takes on more cases for more clients than any other legal services organization in the United States. And it brings a depth and breadth of perspective that is unmatched in the legal profession. Our Civil Practice has offices in every borough of the City, and worked on more than 43,000 individual legal matters last year benefiting more than 100,000 clients and their family members and winning over 90 percent of the cases that go to court or an administrative hearing. An additional two million individuals benefit from the Civil Practice's pending class action litigation.

The Civil Practice works to improve the lives of needy New Yorkers by helping vulnerable families and individuals on issues ranging from health care, housing, homelessness prevention, employment law, education, foreclosure prevention, consumer law, community economic development, public assistance, immigration, family law and domestic violence and disability-related issues. Each year, The HIV/AIDS Representation Project (H/ARP) serves hundreds of individuals living with HIV/AIDS by providing comprehensive civil legal services as well as referrals to health services, HIV/AIDS education, counseling, and other services.

Most often HASA recipients apply for special grants, such as rent arrears or moving expenses, because they pay most of their monthly income towards rent or experience unforeseen emergencies, and not due to substance abuse.

Preventing homelessness of HIV positive low-income New Yorkers is a main area of advocacy and representation provided by The Legal Aid Society's HIV/AIDS Representation Project. Through representing thousands of clients, we have learned that there are many reasons why our clients might fall behind in rent and are then at risk for eviction.

HASA recipients who receive Social Security Disability Insurance or Supplemental Security Income (SSDI or SSI) often pay the majority of their monthly income towards rent. In 2010, the New York State Legislature passed a bill that capped the rent for HASA recipients at 30% of their monthly income, but Governor David Patterson vetoed this measure. We have no doubt that enactment of the 30% cap for our clients would go far in preventing homelessness, and reducing the need for our clients to seek rent arrears. The reality is that it is exceedingly difficult to live on $359 a month in New York City. The struggle to keep up each month with these exorbitant rent payments is a major reason HASA recipients accumulate rent arrears.

Often administrative errors cause HASA to inexplicably stop or reduce paying the agency's portion of the rent directly to landlords. Generally, my clients are unaware that they have accrued rent arrears until they receive a nonpayment petition and are facing eviction in Housing Court. We have advocated for clients where rent arrears accumulated because HASA case managers neglected to properly implement lease renewal increases.

Additionally, HASA recipients fall behind on their rent for the same reasons that impact many other low-income New Yorkers. For example, a family emergency will necessitate a last minute trip out of town to visit an ailing family member. Or to ensure the most thorough possible remediation of bed bugs in their apartments, my clients will often incur expenses above what a landlord will agree to pay. These are just some examples of how the vagaries of life especially impact low-income HASA recipients, and will cause them to occasionally need assistance with rent arrears.

In contrast, substance abuse is not a frequent reason why our clients need special grants such as rent arrears or moving expenses. In those occasional cases in which substance abuse does play a role, we will offer referrals to supportive services to help the individual address those issues while we make every effort to prevent the person from being evicted and rendered homeless. The commitment to stable medically appropriate housing contained in Local Law 49 is the most

fundamental means for ensuring the health and well being of all of our clients, especially for clients who need to address addiction issues.

HASA has produced no clear explanation as to why this new policy was deemed necessary. Is the purpose to save the agency money by limiting special grants for rent arrears, moving expenses, and/or ongoing above-enhanced exception to policy rents? Is the point to help HASA recipients' access treatment for substance abuse? Has there been any inquiry as to whether coercing individuals into treatment and threatening them with homelessness is an effective way to bring them into treatment? We are certain that this new policy will leave many HASA recipients in serious jeopardy of eviction. It is important to fully vet and interrogate the wisdom of this policy change due to its potential to negatively impact the health and welfare of low-income HIV positive New Yorkers.

Delays granting rent arrears puts HASA recipients at risk of eviction from affordable decent housing.

The new policy requires mandatory substance abuse screening before HASA will approve and issue special grants such as rent arrears, moving expenses or approve or continue to pay above-enhanced rental assistance. Before this policy there already existed a multi-step process for HASA recipients to apply for special grants. In all cases the HASA recipient must meet with their HASA case manager who will collect information related to the request, evaluate the HASA recipient's application for a special grant, and have the individual sign paperwork to complete the request. Even before this new policy, delays abounded; due to heavy case loads many case managers are in the field two days a week and unavailable to process these requests and our clients have limited availability to visit HASA due to their numerous medical appointments.

In our experience, any needless delays put HASA recipients in danger of eviction because of the fast pace of summary proceedings in Housing Court. Especially for HASA recipients unrepresented in Housing Court, delays in issuing rent arrears can cause individuals to fall through the cracks. For example, if arrears are not issued by HASA by a court ordered payment deadline and the person is too ill or weak to file a *pro se* Order to Show Cause at Housing Court, then the person will be evicted.

In practical terms we are concerned that the screening and possible referral to a Certified Alcohol and Substance Abuse Counselor (CASAC) will add further delays. We currently lack the full details of how HASA intends implement this policy. However, it is our understanding that if a HASA case manager suspects that an individual may have a substance abuse issue, the person will be first screened by the case manager, and then referred to a CASAC. The CASAC will evaluate and determine whether the individual needs substance abuse treatment and the nature of the treatment. It is unclear how much additional time the CASAC evaluation will add to the process of issuing special grants. It is unclear what will trigger a referral to CASAC. If a person admits to having a drug history, will that trigger the referral? Will case managers make unnecessary referrals out of an abundance of caution? This will delay the issuance of special grants and put the HASA recipients at risk of eviction.

The HRA Commissioner's policy announcement in the Huffington Post indicates that no special grants or above-enhanced rental assistance will be issued by HASA "until proof of substance abuse treatment is established." This raises the question of what is required to demonstrate that the substance abuse treatment is established. Will agreement by a HASA recipient to go to treatment be sufficient? Will the person have to actually begin the treatment or progress to a certain benchmark in the treatment? Or will the person have to complete treatment before receiving a special grant and/or the full ongoing rent for their apartment? These questions highlight the possibility of delays of unknown duration that can derail an individual's ability to maintain medically appropriate affordable housing. Based on my experience representing tenants in Housing Court, I can say that very few landlords will be patient enough to wait weeks or months for their money before sending a Marshal to evict a tenant in arrears.

The new policy should, but apparently does not, offer additional supportive housing placements, which are desperately needed by many eligible for HASA.

The Commissioner's announcement stated that if HASA recipients did not agree to participate in the recommended drug treatment that they would be either denied special grants and/or above-enhanced rental assistance, or "they will be offered a supportive housing placement." The process for placing HASA recipients, who urgently need additional services, in appropriate and decent supportive housing is often long and arduous. Due to lack of resources and tremendous demand, we have seen clients try for months if not years to access supportive housing. They have to repeatedly apply for spots and visit possible placements only to find out that the spot they were referred to was just filled.

Unfortunately, we have learned that the supportive housing offer mentioned in the Commissioner's statement does not in fact refer to any additional supportive housing placements. For some reason, HASA does not anticipate additional need for supportive housing as a result of this policy. This is hard to understand since this policy will likely result in a rise in evictions and homelessness of HASA recipients. This also raises the important question – where will homeless HASA recipients go if not to supportive housing? The only answer we can imagine is that these individuals, who HASA has identified as being in need of substance abuse treatment, will be referred to transitional housing in the various commercial Single Room Occupancy (SRO) units in the City.

A policy that ultimately results with individuals susceptible to substance abuse being transferred from stable long term apartments to SROs is not a policy that can legitimately claim to be designed to help impacted HASA recipients overcome addiction. Anyone who has spent time in such SRO buildings understands that there is often drug use in these buildings and thus they are inappropriate placements for someone with an addiction history or inclination. Many of these facilities have such awful conditions that it is difficult to believe they could be fairly categorized as meeting the standard for medically appropriate housing required by Local Law 49. Furthermore, these substandard units in buildings where drug use is common regularly cost from $2,000 to $2,500 a month. This is more than twice the monthly rent that HASA pays for the majority of my clients to live in their own private apartments. We question the wisdom of this policy as it will cost the City much more to house our clients in SROs, then to help them maintain reasonably priced medically appropriate housing.

The HRA policy implemented last year which limited moving related grants for broker's fees and security deposits critically reduces the opportunity for HASA recipients to access decent affordable housing.

As of February 1, 2011, HRA stopped issuing security deposits for public assistance recipients moving into new apartments, and instead required that landlords accept a voucher promising possible payment when the public assistance recipient vacated the apartment. As of March 1, 2011, HRA reduced by half payment to brokers who assist public assistance recipients secure new apartments. These policies have wreaked havoc on the ability of all New Yorkers on public assistance, including HASA recipients, to access decent housing. For our clients on HASA, these policy changes have made the already challenging process of obtaining good quality housing in this expensive City nearly impossible.

Based on the limited supportive housing options, and the often problematic conditions found in SROs, most of our clients need to obtain private rent stabilized or market rate apartments. Our clients have always faced a number of problems obtaining housing as they must compete for apartments against individuals with employment income. Also, HASA recipients might lose out on apartments if they had a previous Housing Court case or if they have less than stellar credit. One big impediment is that HASA has essentially capped approvals of the above-enhanced rental assistance for individuals at $1,000 per month or less. It is rapidly becoming difficult for our clients to find apartments in any Borough of New York for that amount.

In the past, many of our clients have utilized the assistance of brokers to obtain apartments with prices that HASA would approve. The new policy is a disincentive for brokers to work with HASA recipients as they will only receive half of their usual fee for assisting our clients. The HRA policy states that brokers are not to try to obtain the balance of the broker's fees from our clients, but we have no doubt that this happens anyway. Regardless, most of our clients would not be able to pay half of the broker's fee on their own from their subsistence level of monthly income.

Similarly, the policy that ended payment of security deposits to landlords limits our clients' ability to secure apartments. HASA is asking landlords to accept a voucher that puts the burden on the landlords to demonstrate that they are entitled to recover for damage or unpaid rent after the tenant vacates. After the City recently broke its promise to guarantee payment of Advantage subsidies to landlords, one could not fault landlords for being skeptical as to whether they would get payment based on these vouchers. I know of cases where even after the landlord accepts an individual as a tenant, they continue to prod and cajole the tenant for direct payment of the security deposit.

Finally, this policy cannot make sense financially, and must be actually costing in excess of any purported savings. HASA recipients' reduced ability to access decent private housing leaves many individuals with no other options than remaining in SRO units for months or years. Generally, HASA pays $2,000 to $2,500 per month for these poor quality units, while a private apartment will only cost HASA $1,000 per month or less. Thus, it would be in HASA's best interest to have policies that encourage recipients' efforts to access private apartments. Besides

the cost savings to HASA, easing the way for recipients to move into private apartments helps fulfill the promise of Local Law 49 by housing this vulnerable population in decent medically appropriate apartments.

Conclusion.

We thank the Council and its leadership for calling this hearing, and we look forward to answering any questions and working with you in the future.

Respectfully Submitted,

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FOR THE RECORD

Testimony for the Committee on General Welfare: Hearing on HASA Policy Changes
February 8, 2012

To the Committee on General Welfare,

I am a community organizer at Gay Men's Health Crisis, where I work with many HASA clients who remain in unsuitable living conditions because they cannot find a broker to work with them. These clients see HASA policies as discriminatory and damaging. Here, I want to share the story of one HASA client in Brooklyn who wishes to remain anonymous:

> *It's impossible to find an apartment on HASA when they don't pay the whole brokers' fee. You call all of these brokers, but once you say the "H" word [HASA], no one wants to touch you with a 10-foot pole. They know it's only half the money that they're getting from you, so they want to charge you for the amount they want to get.*
>
> *If you're on disability, you're getting less than $300 per month...you have bills to pay and everything else to do with that money. What do they want us to do? You have to pay for your medications (in copays and public transportation). How much are you able to save and to do what you need to do as a person? To live comfortably until God is ready to take you. I get about $800 from disability, and half of that goes into rent. I have people in my household. My daughter is going to graduate from school, and how can I support her? I can't afford it. I've been looking for an apartment for the longest while....almost two years. We had a whole list of brokers, but I don't deal with them anymore.*
>
> *Brokers are dishonest to try to get rid of you. Once they hear you're from HASA, the rent goes up. It's really hurting us. I called almost each one on the list. One broker said he would show me an apartment, but then found out I was on HASA, and tried to tell me that my family of five was too small to live in a three-bedroom apartment. I know that he made that up because he didn't want to deal with HASA.*

Access to stable housing, free from discrimination, is essential to the health and livelihood of all people, especially those living with HIV/AIDS. Please reconsider this policy.

Thank you,

Liza Behrendt
Community Organizing Coordinator
Gay Men's Health Crisis
446 w 33rd St
New York, NY, 10001

PRUCOL

by

Vishal Trivedi
Immigration Project Coordinator
GMHC – Legal Services Department

130 families
presently receiving
ongoing
Asst. Immed

PRUCOL

What does it stand for?

- Permanently
- Residing
- Under
- Color
- Of
- Law

PRUCOL

- PRUCOL Examples of Eligibility:
  - applicants for asylum
  - adjustment of status applicants
  - voluntary departure applicants
  - deferred action applicants
  - and a general "leftover" category of other non-citizens without an official Immigration designation but whom the Immigration Service knew were here and did not intend to remove.
  - (Does not include those with Temporary Protected Status and non-immigrants, such as tourists and students.)

PRUCOL Status

- Benefits of having a PRUCOL Status
  - Immigrant is able to obtain a limited amount of Public Assistance from HASA.

    - Housing

    - Limited Cash Assistance

    - **Medicaid**

PRUCOL

What does it mean?

- **Immigration Service is aware that a person is "illegally" present in the United States.**

- **The Immigration Service is not taking any steps to deport him / her from the United States.**

Dear members of the NYC Council Committee on General Welfare, thank you for this hearing on HASA new policies.

As a HASA client, I wish to maintain anonymity and protect my identity. I've been a client of HASA since early 90's after receiving an AIDS diagnose. To become a HASA client, with a visa recently expired, following advise from GMHC Legal Services, I applied and was granted PRUCOL. Since them every year I had to produce a PRUCOL letter from the GMHC lawyer. The letter states that GMHC Legal services represent me regarding to my immigration status, that they have filed paper work with Immigration Services and the request was granted. That to date, they have not received any notification from the Immigration Services that any deportation procedures have been initiated against me.That I continue to have a status of a Person Residing Under the Color of Law (PRUCOL). This means that Immigration Services is aware of my presence in the United States, but is not taking any action to put me into deportation proceedings.

I've copies of a power point presentation by a GMHC immigration lawyer that explains what PRUCOL is

Examples of PRUCOL eligibility are:

- Applicants for Asylum,
- Adjustment of status,
- Voluntary departure applicants
- Deferred actions applicants
- and general category

With a PRUCOL Status, PWA immigrants are eligible to limited amount of public assistance from HASA with rent, limited cash assistance (around $380,00 /mo) and MEDICAID/ Managed health care plan.

On mid 2011, my HASA case worker informed me that the PRUCOL letter from the GMHC lawyer alone would not be enough, that I'd have to bring a letter directly from Immigration Services. That request is extremely troubling, it has cause a great deal of stress and anxiety. First because Immigration Services backlog will not allow the furnishing of letters, because of a HASA demand. Secondly and most importantly, PWA on PRUCOL who are HASA clients, fear that such request may trigger deportation procedures.

This new policy from HASA, is closing cases of immigrant clients on PRUCOL. Agencies that provide immigration services to PWAs are trying to prevent that , still client cases are being closed. In consultation with a representative from African Services (who provide housing assistance to PWA who don't qualify for HASA), this week alone (today is Wednesday), 3 clients who qualified for PRUCOL were referred to their sustainable living fund, which with its limited resources provides housing assistance, so the clients would not become homeless.

This policy is ultimately increasing homelessness among PRUCOL PWA living in NYC and may very well work against the City efforts to reduce HIV transmission rates and death.

Thanks for your interest and consideration,

A PWA HASA client on PRUCOL

4/ the record

2/6/12

To the Committee on General Welfare,

Right now, I live in an SRO. I just had dialysis for the 2nd time and I'm in the hospital. I'm going back to the hotel because I have nowhere else to go. In order for me to get a decent place, I have to go through the system, because HASA no longer pays the full brokers' fee.

I'm trapped in a Catch 22: I'm coming out of the hospital, I live in an SRO, and I can't go to a broker because, who's gonna take me? I don't have money! I've been looking for a place to live for 4 or 5 months. I've tried to talk to brokers and a lot of them tell me no. When I say HASA, they say no. I've talked to maybe 40 brokers. The ones that do work with HASA now are greedy for money. My daughter lives with someone who gets HASA and their apartment is dirty and roach-infested, and they just moved in.

We can't pay the broker. I've heard stories where people pay their broker fee and end up with nothing. And what about somebody that doesn't know what I know? What do they do? How about someone who's been diagnosed for the very first time? We can't pay the broker. I think you really need to look into this a little more, because it's really not fair.

Carol Ntuli

Currently residing at:

2350 Davidson Ave
Bronx, NY, 10468.
Room 215.

4-the record

Testimony to the Committee on General Welfare: Hearing on HASA Policy Changes
February 8, 2012

To the Committee on General Welfare,

I've been in the South Bronx for 15 years. Now I'm downtown in Brooklyn, for 3 years. The conditions are unsanitary and unsafe. Nobody makes repairs. I have no working stove or oven, and the refrigerator needs repairs because it leaks. I've been trying to clean the floor for years, but it is in terrible condition. The water is not good. My fiancé has asthma and the air is poor. I want to move out and get my own apartment, for the health and safety of me and my fiancé. I need to be comfortable.

Many people in my community are also living in uncomfortable conditions and want to move elsewhere, for their health. But the brokers' fee adds another barrier to finding safe housing. Please pay the full brokers' fee for HASA clients. We should have good policy for citizens who are born here to be able to find housing.

Marion H Miller Jr.
Common Ground
160 Schermerhorn St.
Brooklyn, NY, 11201

4 the record

Testimony to the Committee on General Welfare: February 8, 2012 Hearing on HASA Policy Changes

To the Committee on General Welfare,

I am a HASA client who has been in the city of New York for seven years. I lived in an SRO for six years. My HASA worker told me I could acquire an apartment. When I finally found one, HASA would only pay one half of the brokers' fee and I would have to pay the first and last months' rent and security deposit. I receive only $179.00 bi-weekly along with $200 per month in food stamps. With that money I must provide for my personal needs and pay for my utilities. It would be impossible to even save that amount of money.

It just doesn't make sense that the government would pay upwards of $2,000 for a one month stay in an SRO, which can last for one year, or more. This is very wasteful and could undermine what HASA was initially meant to achieve.

Please reconsider this policy!

Belinda

Client of HASA and GMHC

FOR THE RECORD

Testimony for the Committee on General Welfare Hearing on HASA Policy Changes
February 8, 2012

To the Committee on General Welfare,

Now I'm stably housed, and have been for ten years. But I am concerned about the brokers' fee because I had a similar situation ten years ago, when I had a problem with the brokers' fee and rent. The landlord required money up front, and a lot of them didn't want to accept HASA. When HASA started to pay security deposits and monthly rents came on time, landlords were more willing to work with us.

I moved out from my first apartment to my next apartment, I had issues with my first apartment. It was bug-infested and I felt like I was penalized with the brokers' fee and the security deposit. I needed to pay twice the same amount of money. It took time because after I paid, I still had to get an approval from HASA. When I mentioned it to HASA, I thought they were going to recoup the money. She didn't say anything about the brokers' fee. If I didn't have the money myself, I would have been lost or homeless. It was a big chunk of change: at least $600. The broker asked me to pay the brokers' fee and the landlord asked me to pay the security deposit.

I feel that people need the brokers' fee and the deposit in order to be stable and consistent. The problem is that the landlord doesn't believe that they'll get the payment. Also, some landlords discriminate with HASA clients and Section 8 clients.

Gayle D
Client of HASA and GMHC
Queens

Testimony of
Cathy Bowman
South Brooklyn Legal Services

City Council General Welfare Committee
HASA Oversight Hearing

February 8, 2012

On World AIDS Day, HRA Commissioner Robert Doar announced on the Huffington Post, of all places, that HASA had begun systematically screening clients for alcohol and substance abuse for the first time. Emails from advocates to HASA staff revealed that there were in fact new substance abuse policies in place, and a Freedom of Information Law request disclosed a procedure alert from September 30, 2011. These new policies had not been publicly presented, discussed, or noticed for comment prior to their implementation.

Although the procedures do not appear to have been fully implemented at this time, the language of the procedure alert is alarming and contrary to current data on improving health outcomes for people living with HIV/AIDS, achieving success in substance abuse treatment, and acknowledging the primacy of housing for both health and the reduction of substance use for PLWHA. What is HRA seeking to achieve? What are the goals of this new policy? In the abstract, few would argue with objectives such as improving the health of people living with HIV, reducing self-destructive behaviors associated with substance abuse, or assisting people who would like to return to work to accomplish that aim. Unfortunately HASA's new substance abuse policy seems to run counter to these objectives and ignores the realities of many of the clients it serves, many of whom have been determined to be disabled.

Housing must be prioritized over substance abuse treatment

Housing is more critical than substance abuse treatment in predicting response to medical treatment for PLWHA. People living with HIV/AIDS benefit from housing whether they are using drugs or not. Evidence suggests that use-tolerant housing models achieve stability and access to services outcomes comparable to more traditional

abstinence-only housing models.[1] A more productive plan would be for HASA to focus on housing first and provide additional support for substance abuse treatment from there. Extensive social science research over the past ten years has clearly established that housing status is among the strongest predictors of entry into HIV care, primary care visits, continuous care, and care that meets clinical practice standards.[2] The New York State Medicaid Restructuring Team has acknowledged the importance of housing to the health of PLWHA. Having a stable place to live can make the difference between having access to benefits and adherence to medical regimens or not.[3] The death rate due to HIV/AIDS is seven to nine times higher among homeless adults compared to the general population.[4]

Stable housing also reduces rates of infection throughout the community. Individuals with low viral loads (linked to adherence to medication regimens) are less likely to pass on the virus. Individuals without housing are more likely to engage in unsafe sexual practices in return for money or a place to sleep. The substantial societal costs include increased rates of hospitalizations for publicly insured individuals, exorbitant rental fees at SROs and shelters, and increased rates of HIV infection throughout the community.

HASA's new procedure will further destabilize PLWHA with substance abuse problems who are unable to stay clean or otherwise comply with treatment. If homelessness were a cure for substance abuse, New York City already would have experienced a dramatic decrease in addiction. Nonetheless, HRA's new policy would sanction HASA clients for failure to comply with alcohol and drug abuse screening and assessment, including closure of a client's emergency housing placement until he

complies. This appears to directly violate HASA clients' right to "medically appropriate transitional and permanent housing" pursuant to NYC Code § 21-128(b).

Perhaps the greater damage will come from the punishment for failing to comply with the required treatment, often an ongoing and lengthy process. The procedure alert states "[f]ailure to comply with the substance abuse treatment referrals/recommendations made by a CASAC will result in either loss or reduction of cash benefits." Cash benefits include not just the cash that clients use to pay for everything in their daily lives other than food, but also rental assistance. While it is unclear whether HASA plans to follow the state-wide regulations regarding substance abuse sanctions, those penalties are harsh. For the first failure to participate, the sanction period is 45 days or until the "failure ceases," whichever is **longer**. The second sanction is for 120 days and thereafter for 180, or until compliance, whichever is longer. OTDA does not pay rent arrears for a time period in which a client was sanctioned. Failure to comply with substance abuse treatment even for short periods will certainly result in evictions.

In addition to the harm to the clients, the new policy makes no fiscal sense. Permanent housing is more cost effective than emergency housing. Emergency housing is $56 per day for an individual ($1697 per month), $81 per day for a family ($2455 per month), and $68 in facilities operated by community based organizations ($2061 per month). Meanwhile, the City is not expanding supportive housing for PLWHA. Substantial costs are likely to be shifted to Medicaid and medical providers.

Many HASA clients are disabled and work-exempt

While HRA's new substance procedure references New York Social Services Law §132(4), that statute is focused on enabling the applicant or recipient to participate

in work-related activities.[5] HASA clients are not required to participate in work activities and are classified by HRA as "indefinitely unengageable." A substantial portion of HASA clients have been found by the federal government to be fully disabled: as of December, 2011, 14,075 HASA clients (43.6%) were receiving SSI and/or SSD. This raises the question of HASA's motivations in requiring substance abuse screening and treatment for clients to receive benefits and services when these individuals are exempt from work requirements.

It also raises questions of legality. How can HASA require disabled individuals to participate in work-related activities? HASA appears to be adding an eligibility requirement that would not apply to other public assistance recipients. NYC Code § 21-128(b) states that "[t]he requirements with respect to such access to and eligibility for benefits and services shall not be more restrictive than those requirements mandated by state or federal statute, law, regulation or rule."

Unfortunately, it is the HASA population with income from SSI and SSD that is most likely to be facing eviction, requesting rental arrears, and seeking grants to move. This population is required to pay a share of their rent from their SSI/SSD. After their rent share is paid, each client is left with $359 in cash per month for all other expenses (except food). These clients do sometimes fall behind on their rent, although not always because of alcohol or substance abuse problems. Living on $359 per month is not easy. The statewide 30% rent campaign for people with symptomatic HIV is designed to reduce the rent burden for this population. While the health of some of these clients will improve and allow them to return to work, this is by no means true for everyone. While

they continue to receive federal disability benefits, they must be acknowledged as disabled for purposes of work.

If HASA were serious about assisting clients in returning to employment, it should focus more energy and resources on job training and placement. Permanent job placement has proven extremely difficult for HASA clients, apparently because employers are hesitant to take a chance on welfare recipients with HIV. More incentives to employers would help HASA clients actually return to the work force. HASA clients regularly tell me that they are looking for work but are having a difficulty finding a job (which is not surprising in the current economy). These clients would be delighted if HASA could offer them some appropriate and realistic job opportunities.[6] A look at HASA's own statistics tells a stark story of their commitment to employment opportunities. As of December 2011, only 15 clients were in work readiness groups; 14 were in skill day sessions; 3 were in individual counseling sessions, 8 were in job club, 2 were in computer training; and **none** were in full/part time employment through HASA. One has to wonder how many HASA clients even know that these services exist.

---

[1] Bendixen, A. (2006). The relationship of housing status and health care access: Results from the Chicago housing for health partnership. Presented at the Second National Housing and HIV/AIDS Research Summit, Johns Hopkins University, Baltimore, MD.; Wilkins, C. (2006). Housing status and health care access. Presented at the Second National Housing and HIV/AIDS Research Summit, Johns Hopkins University, Baltimore, MD.; Martinez, T.E., & Burt, M.R. (2006). Impact of permanent supportive housing on the use of acute care health services by homeless adults. Psychiatric Services, 57(7), 992-999.

[2] Aidala, A., Lee, G., Abramson, D., Messeri, P. & Siegler, A. (2007). Housing need, housing assistance, and connection to medical care, AIDS & Behavior, 11(6)/Supp 2: S101-S115.

[3] *Id.*

[4] Kerker, B., Bainbridge, J., Li, W., Kennedy, J., Bennani, Y., Agerton, t., Marder, D., Torian, L., Tsoi, B., Appel, K., Gutkovich, A. (2005) The Health of Homeless Adults in New York City: A report from the New York City Departments of Health and Mental Hygiene and Homeless Services.

[5] While anyone can be screened, "[t]he social services official shall refer applicants and recipients whom it determines are presently unable to work by reason of their need for treatment for alcohol or substance abuse based on the formal assessment to a treatment program... ." NY SSL §132(4)(c). Only if the assessment determines that "the applicant or recipient is unable to work by reason of his or her need for treatment for alcohol or substance use" must the individual be referred for treatment. 18 NYCRR 351.2(i)(1)(iii). The treatment plan must include "an expected date of availability for work related activities." 18 NYCRR 351.2(i)(1)(iv)(b). If the assessment determines that the individual is abusing alcohol and/or drugs but is able to work, the eligibility process should continue in accordance with existing procedures. 97 ADM-23.

[6] It should be noted that 1194 HASA clients had earned income as of December 2011.

2/7/12

Hi,

My name is Jada Frederick. I am HASA. I'm currently looking for apartment, but because of 30% rent cap and broker's fee for the apartment, but I can't afford it, because of this broker's fee situation. I barely can pay my bills so I need this badly.

Sincerely,

Jada Fredericks

2/7/12

To Whom This May Concern:

I am a new resident to NYC. I was approved for HASA. I was excited to that I can move. However, upon that journey of searching for an apartment. I found that I had to pay security deposit, first month's rent, and then half of the broker's fee. Which is $500.00. Now how is that possible when I'm not even receiving that much money? How a I supposed to live after doing that? That isn't right. They need to get rid of it.

Tori McKethan

Dear Sir/Madam,

My name is La'Shaye Simmons and I'm HIV + since '04. I recently went to apply for permanent housing. Unfortunately I couldn't get the apartment because of negligence of my caseworker and the broker's fee. I only get $180 every 2 weeks,, and that's not enough for anyone to live off of. Please if you could remove this broker's fee, so individuals like myself can have stable housing and better living conditions.

Thank You,

La'Shaye Simmons

2/7/12

To Whom It May Concern:

I am a person and a recent voter, but I am having problems because there is no way I can get apartment because of this new broker's fee law. I have no money to pay broker's fee. What am I supposed to do, live in the street? I am HIV/AIDS positive.

Anonymous

FOR THE RECORD

Testimony to the Committee on General Welfare: Hearing on HASA Policy Changes
February 8, 2012

To the Committee on General Welfare,

The purpose for HASA is unique and one of a kind in the country. But these new policies do great harm to the clients that HASA represents. Now a person has to take the limited funds they already have to secure adequate housing. There is harm being done, but the agency exists to help us, not to hurt us. The agency should be advocating on behalf of clients, not doing things that are harmful to their health.

If you're on a limited income, putting the majority of money into rent, you still need a good place to live. If a landlord tells you to support half of a brokers' fee to secure an apartment, where are you going to find it? How can you get the money to secure the lease? The stress and insecurity makes a person with HIV's T cells and viral load go out of whack. You might have to sell your medication in order to pay for the brokers' fee. And then you might be penalized for coming up with that money: you're penalized many times for your health. You don't have the money to fight this in court.

The bottom line is that this HASA policy makes people homeless. The welfare of HRA clients is at stake.

Thank you,

Albert Hendrix
272 Sherman Ave, Suite 2C
New York, NY, 10034

VILLAGECARE

Community Case Management
112 Charles Street
New York, New York 10014
tel 212.337.5705 fax 212.337.5759
www.villagecare.org

David H. Sidwell
Chairman

Emma DeVito
President & CEO

FOR BETTER HEALTH AND WELL-BEING

Wednesday, February 8, 2012

HASA Oversight Hearing

As a Supervisor working specifically with HIV+ young gay men of color, I have many stories of clients who have been impacted by the new HASA policy regarding security deposits and broker's fees. The most common experience many clients share is that they are often asked to come up with the other half of the broker's fee. I have known clients who have planned on using the furniture voucher they receive to compensate the brokers for the other half of their fee, have borrowed money from loan sharks which then causes many other problems, but more often the clients resort or return to sex work.

Of course they told such practices as paying the brokers any additional money is not advisable, the common issue is that it makes it so much harder to find reputable brokers. Many times brokers are unwilling to work with HASA clients because they know already they won't receive their full fee. In addition, many brokers have relationships with landlords that we as social service providers do not. So without the broker acting as a liaison we are left working with unscrupulous realtors and landlords who are more concerned with "guaranteed rent" that HASA provides than providing quality and safe apartments for our young, homeless, and often desperate clients who are often looking to stabilize themselves.

Howard H. Haughton, MSW
Program Supervisor
Supportive Case Management Programs
Tel. 212.337.5714
Cell: 646.734.6459

FOR THE RECORD

FEDERATION OF PROTESTANT WELFARE AGENCIES

TESTIMONY

Of

The Federation of Protestant Welfare Agencies

Before the

New York City Council General Welfare Committee

Oversight: Recent Policy Changes at HASA

February 8, 2012

Prepared by:

Esther W. Y. Lok – Assistant Director of Policy, Advocacy and Research and Senior Policy Analyst for HIV and AIDS

Federation of Protestant Welfare Agencies, Inc.

281 Park Avenue South
New York, New York 10010
Phone: (212) 777-4800
Fax: (212) 533-8792

Fatima Goldman

Executive Director/CEO

Good afternoon. My name is Esther Lok and I am here to represent the Federation of Protestant Welfare Agencies (FPWA). I would like to thank Chairwoman Palma and members of the General Welfare Committee for the opportunity to testify today and for your continued leadership on behalf of low-income New Yorkers living with HIV/AIDS in need of public assistance.

FPWA is a membership organization with a network of human service organizations and churches that operate over 1,200 programs throughout the New York City metro area. Together we serve over 1.5 million low-income New Yorkers of all ages, ethnicities and denominations each year.

This testimony responds to recent policy changes, implemented by the HIV and AIDS Service Administration (HASA), a division of the Human Resource Administration (HRA), which are the reduction of the brokers' fee, the vouchering security deposit and the enforcement of clients' compliance with substance abuse treatment.

Brokers Fee Reduction and Vouchering Security Deposit

Effective April 2011, HRA changed its policy to compensate brokers who work with recipients of public assistance in search of housing in private market by reducing 50% of the fee. Simultaneously, HRA also changed its policy to pay security deposit to landlords in a form of voucher instead of cash. Since then, recipients of public assistance, particularly those who receive HASA benefits, have encountered enormous challenge in finding housing as the list of brokers that are wiling to work with HASA clients has drastically reduced and many landlords are not willing to rent their apartments to clients unless they are able to find cash as security deposit.

According to an online survey conducted by Shubert Botein Policy Associates, 238 responses were collected from case management providers who assist HASA clients to find and secure private market housing at 44 different community-based organizations. Survey respondents reported that these changes have significantly affected HASA clients they serve, with the change of brokers' fee being the most challenging. Findings of the survey show:

- Over 95% of clients involved in a housing search have experience one or both policy changes as a barrier to housing placement;
- 79% of respondents report that the security deposit change poses a significant barrier to their clients;
- 94% report that the brokers' fee change is a significant barrier, with 50% reporting that it has prevented placement for one or more clients

Compliance with Alcohol and Substance Abuse Treatment

On September 30, 2011 HASA released a procedure alert to its workers with regards to referral of HASA clients to the Credentialed Alcohol and Substance Abuse Counselor (CASAC). This document entailed policy and procedures that all HASA clients are required to perform alcohol and substance abuse screening when applying for cash assistance, benefits and/or face-to-face recertification replacement of lost or stolen benefits, new apartments, rent and utility arrears, rent increases, emergency housing placement through the Emergency Placement Unit, multiple CBIC card replacements and when they exhibit possible signs of alcohol and/or substance abuse.

According to New York State Office of Temporary and Disability Assistance, the purpose to conduct the alcohol and substance abuse screening is to determine employability of adult members of households or heads of households who are applying for public assistance. For those who are determined not employable as a result of their alcohol/drug abuse problem, he/she must comply with appropriate treatment or be removed from the public assistance case. While this approach may be applicable to the general population, it makes little sense to apply to HASA clients. This is because in addition to being poor, they must have an AIDS diagnosis in order to be eligible for HASA benefits. In reality, only an extremely small portion of HASA clients actually have the ability to fulfill work requirements.

Furthermore, a supportive environment is essential to an effective alcohol and substance abuse treatment. Commissioner Doar's notion of removing HASA clients' ability to receive above-enhanced rental assistance or denying their request for rent arrears payments based on their compliance with CASAC recommended treatment is a punitive approach that FPWA does not support. When an individual decides to confront with his/her substance abuse problems and to take action to address them, treatment should be made available as a support, rather than using it to hold clients hostage.

Another way to improve HASA clients' compliance with CASAC recommended alcohol and substance abuse treatment is to develop better communications between HASA case workers and CASACs. For example, HASA case workers and CASACs can share appointment information of clients who are expected to be engaged in treatment so that no meetings with HASA case workers and counseling sessions or treatment would be scheduled on the same day or at the same time.

Conclusion

In the policy paper of the North American Housing and HIV/AIDS Research Summit Series published in 2011, it concluded that housing status is a key determinant of worsening HIV health disparities. For people living with HIV, homelessness and unstable housing are strongly associated with inadequate HIV health care, poor health outcomes and early death. (Wolitski, et al., 2007) Compared to their peers who are stably housed, persons living with HIV who lack stable housing: are more likely to delay HIV care; have poorer access to regular care; are less likely to receive 4 optimal antiretroviral therapy; and are less likely to adhere to therapy (Kidder, et al., 2007; Aidala, et al., 2007; Leaver, et al., 2007). Homeless people with HIV experience worse overall physical and mental health than their housed counterparts, have lower CD4 counts and higher viral loads, and are more likely to be hospitalized and use emergency rooms. (Kidder, et al, 2007) Homelessness is independently associated with HCV/HIV co-infection (Rourke, et al. 2011), and the death rate due to HIV/AIDS is seven to nine times higher among homeless persons than in the general population. (Kerker, 2005; Walley, et al, 2008; Schwarcz, et al., 2009)

These research findings highlight the importance of stable housing for people living with HIV/AIDS, and its role in HIV prevention. FPWA feels strongly that it is imperative of HRA and HASA to consider the provision of stable housing and housing assistance a top priority. Recent policy changes of HRA and HASA discussed in this testimony would only hinder this goal and therefore, should be rescinded.

Thank you for the opportunity to share our concerns.

Testimony to the Committee on General Welfare: Hearing on HASA Policy Changes
February 8, 2012

To the Committee on General Welfare,

The purpose for HASA is unique and one of a kind in the country. But these new policies do great harm to the clients that HASA represents. Now a person has to take the limited funds they already have to secure adequate housing. There is harm being done, but the agency exists to help us, not to hurt us. The agency should be advocating on behalf of clients, not doing things that are harmful to their health.

If you're on a limited income, putting the majority of money into rent, you still need a good place to live. If a landlord tells you to support half of a brokers' fee to secure an apartment, where are you going to find it? How can you get the money to secure the lease? The stress and insecurity makes a person with HIV's T cells and viral load go out of whack. You might have to sell your medication in order to pay for the brokers' fee. And then you might be penalized for coming up with that money: you're penalized many times for your health. You don't have the money to fight this in court.

The bottom line is that this HASA policy makes people homeless. The welfare of HRA clients is at stake.

Thank you,

Albert Hendrix
272 Sherman Ave, Suite 2C
New York, NY, 10034

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Felicia Carroll on behalf of Dorella Walters

Address: 57 willoughby st

I represent: Dorella walters

Address: _____

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/2012

(PLEASE PRINT)

Name: Carlos Guevara

Address: 19 Winthrop St. Brooklyn NY 11225

I represent: CAHBA. Inc.

Address: 19 Winthrop St. Brooklyn NY 11225

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☑ in opposition to HASA policies

Date: 2/8/2012

(PLEASE PRINT)

Name: Kendall Lynnette M. Moses, Esq.

Address: 15 Maiden Lane 18th Floor 10038

I represent: HIV Law Project

Address: _____

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THE CITY OF NEW YORK

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Date: 02/08/12

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Name: Yves GERHARDT

Address: 1997 Lexington Ave. Apt. 3A NYC 10035

I represent: Self.

Address:

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Belinda Chandler

Address: 4360 Furman Ave

I represent: GMHC

Address:

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: Feb 8, 2012

(PLEASE PRINT)

Name: Esther W. Y. LOK

Address: 281 PARK AVE S. NY 10010

I represent: Federation of Protestant Welfare Agencies

Address: Same as above

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(PLEASE PRINT)

Name: Orlando Cotto

Address: 2970 W 24th St Apt 3-C7 Brooklyn NY 11224

I represent: My Self

Address: 319 W 109th St Apt 81Z NY NY 10025

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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/21

(PLEASE PRINT)

Name: Sarah Bull

Address: 977A Putnam ave

I represent: Housing Works

Address: 2640 Pitkin ave

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Appearance Card

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☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Shirlene Cooper

Address: 1045 Ocean ave #1 BKlyn NY 11226

I represent: Housing Works

Address: 57 Willoughby St

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Edline Jacquet

Address: 247 W. 37th Street, NYC, NY 10018

I represent: Supportive Housing Network of NY

Address: _____

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: [illegible]

Address: [illegible]

I represent: [illegible]

Address: [illegible]

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: Cathy Bowman

Address: 355 Clinton Ave Brooklyn 11238

I represent: South Brooklyn Legal Services

Address: 105 Court St Brooklyn 11201

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Date: _____

(PLEASE PRINT)

Name: Ing. J. Soto

Address: 479 Willoughby Ave, 1R BKLYN NY 11207

I represent: GMHC

Address: 446 West 33rd St NY NY 10011

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 2/8/2011

(PLEASE PRINT)

Name: Lyndel Urbano

Address: 446 W 33rd St. NY, NY 10001

I represent: GMHC

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Henry Horne

Address: 14E. 28 ST - APT 1109

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Elizabeth (Liza) Behrndt

Address: 205 Gates Ave, Brooklyn, NY 11238

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: Dr. Frank Cipton, Deputy Commissioner CAS

Address: 180 Water Street, NY, NY

I represent: HRA

Address: 180 Water Street, NY, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: Jacqueline Dudley, Deputy Commissioner HRA

Address: 180 Water Street, NY, NY

I represent: HRA

Address: 180 Water Street, NY, NY

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 2/8/2012

(PLEASE PRINT)

Name: WANDA HERNANDEZ

Address: 684 E. 189th ST. 1B

I represent: VOCAL-NY

Address: 80A 4th AVE BROOKLYN NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: Kristin Goodwin

Address: _____

I represent: Housing Works, Inc.

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: GINNY SHUBERT

Address: _____

I represent: SHUBERT-BOTEIN POLICY ASSOCIATES

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: WANDA HERNANDEZ

Address: _____

I represent: VOCAL-NY

Address: 80-A FOURTH AVE, BROOKLYN NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Manuel Pucret 3rd

Address: 2532 Creston Avenue A-8 Bx N.Y. 10468

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8

(PLEASE PRINT)

Name: HARRIET COHEN

Address: ~~[illegible]~~

I represent: AIDS Center of Queens Co

Address: 162nd St + Jamaica Av

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: Helene Rusby

Address: The Legal Aid Society, 230 E. 106th St, New York, NY

I represent: Legal Aid Society

Address: 230 E. 106th St., New York, NY 10029

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Howard H. Hayton

Address: 560 Isham St Apt. 1J

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

Date: 02-08-12

(PLEASE PRINT)

Name: Ramiyue Green

Address: _____

I represent: M.S.U.

Address: 17 Riverside, NY 10025

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: Elsie Mann

Address: 312 W

I represent: PRAXIS HOUSING INITIATIVES INC.

Address: 312 West 109th St. N.Y., N.Y. 10025

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Gyle D.

Address: Queens, NY

I represent: HASA

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: HASA CLIENT ON PRUCOL

Address: MANHATTAN

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☑ in opposition

Date: 2/8/12

(PLEASE PRINT)

Name: Michael Hester

Address: 306 Lenox Ave.

I represent: Harlem United

Address: 306

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Scott Stenoff

Address: 305 7th Ave NY NY

I represent: The Partnership fn the Homeless

Address: 305 7th Ave

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2-8-2012

(PLEASE PRINT)

Name: MARIA LUISA MIRANDA

Address: 13878 HOOVER AVE

I represent: JAMAICA NY, 11435

Address: ME

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 2/8/2012

(PLEASE PRINT)

Name: Angel Resto

Address: 386 W187 ST

I represent: Foundation House North

Address: SAME AS ABOVE

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: DWAYNE A MOYE

Address: 1068 FRANKLIN AVE.

I represent: SACHR Adult Day Center

Address: 310 CARLTON AVE

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

Date: 2.8.12

(PLEASE PRINT)

Name: Jodz Joseph

Address: 27 Winthrop St BROOKLYN NY 11225

I represent: CAMBA

Address: 27 Winthrop St BROOKLYN NY 11225

Please complete this card and return to the Sergeant-at-Arms