CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON GENERAL WELFARE

Jointly with the

COMMITTEE ON HEALTH

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HELD AT: COUNCIL CHAMBERS, CITY HALL

B E F O R E: Diana I Ayala, Chairperson
Lynn C. Schulman, Chairperson

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A P P E A R A N C E S (CONTINUED)

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SERGEANT AT ARMS: Good morning and welcome to the New York City Council hearing of the Committee on General Welfare, jointly with Health. At this time, can everybody please silence your cellphones. If you wish to testify, please go to the back of the room to fill out a slip with the sergeant at arms.

At this time and going forward, no one is to approach the dais. I repeat, no one is to approach the dais. Chairs, we are ready to begin.

CHAIRPERSON AYALA: Thank you and good morning, everyone. My name is Diana Ayala and I am the Deputy Speaker of the New York City Council and the Chair of the General Welfare Committee. We are here today to hold an important oversight hearing on the administration of the city's HASA program.

HASA, the city's HIV-AIDS Services Administration, was established in 1985 by HRA. And now, 40 years later, it still provides critical case management and assistance to low-income New Yorkers who have been diagnosed with HIV.

HASA served more than 50,000 New Yorkers in 2024. HASA clients come from every borough in the city, are referred from hospitals and CBOs, and receive much-needed rental assistance, access to emergency

housing, and support to apply for benefits. HASA does important work, and the communities are troubled by reports of its shortcomings. According to HRA's own data, HASA has been unable to meet its legally required case ratios since the Adams administration took office.

A hallmark of the HASA program is the low case ratios that ensure clients can receive intensive case management. The population of New Yorkers with an HIV diagnosis is aging, and it remains to be seen whether HASA is fully prepared to meet their needs.

In our deeply uncertain political climate, and under a presidential administration that rejects science and ignores our most vulnerable communities, New Yorkers will be relying even more on New York City to support and protect them. We look forward to hearing from the representatives of the administration about the operations of the HASA program, and how they plan to meet the evolving needs of HASA clients. We will be hearing a pre-considered intro, sponsored by Chair Schulman, who will discuss her bill further, and a resolution, Resolution 175, sponsored by Councilmember Ossé, in support of S183/A.2418, which would amend the social services

law to mandate each local department of social services link persons living with HIV with benefits and services, and provide that persons living with HIV who are receiving housing assistance shall not be required to pay more than 30% of household income towards shelter costs. We thank the administration for joining us today, and also thank advocates and individuals who are here today that can speak to their direct experience with HASA.

I would like to thank the General Welfare Committee, staff who worked hard to prepare this hearing, including Sahar Mouzami, Assistant Deputy Director, Nina Rosenberg, Policy Analyst, Julia Jaramus, Unit Head, Faria Rahman, Finance Analyst, Elizabeth Childers-Garcia, Finance Analyst, Ann Driscoll, Data Analyst, and finally my staff, Elsie Encarnacion, Chief of Staff.

I would now like to turn it over to my co-chair for her opening remarks.

CHAIRPERSON SCHULMAN: Thank you, Chair Ayala. Good morning, everyone. I am Councilmember Lynn Schulman, Chair of the New York City Council's Committee on Health. Thank you for joining us at today's hearing on HASA and on my pre-considered

introduction which would update the eligibility language for HASA services to include any person with HIV, and Resolution 175 sponsored by Councilmember Chi Ossé, relating to the provision of housing assistance and supportive services for individuals living with HIV across New York State.

It's important to recognize the immense progress that has been made over the years in addressing the HIV-AIDS epidemic. It is equally essential to acknowledge that this progress is fragile and requires sustained commitment.

According to DOHMH, in 2023, over 1,500 people in New York City were newly diagnosed with HIV. This is an almost 8% increase from 2022 in contrast with the year-to-year decline in new diagnoses since 2001. It cannot go unmentioned that the federal government plays a central role in funding HIV-AIDS services through programs like the Ryan White HIV-AIDS Program, and it is unclear how reliable those funding sources will be in the near future. Potential cuts to Medicaid and changes to healthcare policies like the Affordable Care Act could lead to fewer people receiving insurance coverage for HIV-related services, medications, and testing.

These are all very real possibilities, and simultaneously, we are seeing rollbacks of protections for the LGBTQ-plus community that could lead to increased discrimination in healthcare settings. In light of all this uncertainty, New York City must step up to ensure that our most vulnerable residents have access to the care, resources, and support that they need and deserve.

As Chair Ayala mentioned, HASA has been a lifeline for thousands of New Yorkers living with HIV and AIDS. It provides critical services from housing assistance to medical care and case management, ensuring that individuals can live with dignity, respect, and access to the treatment they deserve. This Council understands that we are not just protecting the health of our residents. We are protecting the values that make New York City compassionate and inclusive.

The HIV-AIDS crisis is far from over, and as long as New Yorkers continue to live with HIV and grow older, we must continue to support them with a robust and reliable response. We must ensure that New York City remains a model of hope, progress, and

leadership in the fight against HIV-AIDS in these uncertain times.

I want to conclude by thanking the committee staff for their work on this hearing, Committee Council Sarah Sucher, Chris Pepe, Policy Analyst Joshua Newman, and the Finance Staff Danielle Heifetz and Florentine Cabour, as well as my team, Jonathan Boucher, Kevin MacLear, and Abigail Zucker.

I now turn the mic back to Chair Ayala.

CHAIRPERSON AYALA: Thank you. I want to acknowledge that we've been joined by Councilmembers Avilés, Cabán online, Ossé, Ung, Narcisse, Ariola, Marmorato is also online, and so is Councilmember Feliz.

I will now turn it over to the Policy Analysts who swear in members of the administration.

COMMITTEE COUNSEL: Panelists, please raise your right hand. I will read the affirmation once, and then each of you will respond.

Do you affirm to tell the truth, the whole truth, and nothing but the truth before this committee and to respond honestly to Councilmember questions?

MR. ROJAS: Yes.

DEPUTY COMMISSIONER DUDLEY: Yes.

ASSISTANT COMMISSIONER BRAUNSTEIN: Yes.

COMMITTEE COUNSEL: All right, you may begin.

MR. ROJAS: Good morning, Deputy Speaker Ayala, Chair Schulman, and members of the Committee on General Welfare and the Committee on Health. My name is John Rojas, and I serve as Chief Special Services Officer at the Human Resources Administration within the Department of Social Services.

My portfolio, among other things, includes oversight of the city's HIV-AIDS Services Administration. I would like to thank the committees for the opportunity to testify today on our work to support New Yorkers living with HIV and AIDS to live with a better quality of life and more independently. I am joined by my colleagues, Jacqueline Dudley, Deputy Commissioner of HASA, and by Dr. Sarah Braunstein, Assistant Commissioner of the Bureau of Hepatitis, HIV, and STIs from the New York City Department of Health and Mental Hygiene.

HASA began as the Division of AIDS Services 40 years ago. In 1985, dedicated New York City policy makers, advocates, clinicians, and public servants saw the prejudice and ignorance this vulnerable population faced. In the face of that prejudice and

ignorance, they joined together to stand up a city-dedicated program serving individuals living with HIV and AIDS.

Much has changed since 1985, when the epidemic began to rapidly spread across our city and the nation, and the city was the epicenter of HIV-AIDS epidemic. At that time, there were no effective treatments and people did not live long after they became ill.

New York City was among the first municipalities to stand up a range of critical services and support for those affected by HIV and AIDS. Today's epidemic is vastly different from decades past. Medical advances, along with critical services provided by HASA, have allowed low-income New Yorkers with HIV to live long, higher-quality lives.

But much remains to be done, and HASA continues to play a crucial role in stabilizing this vulnerable population, combating stigma, and tackling the inequities that persist.

HASA provides those living with HIV vital assistance with housing, comprehensive case management, and connection to numerous public benefits and services, including Medicaid,

Supplemental Nutritional Assistance Program benefits, cash assistance, temporary housing, supportive housing, rental assistance, home care and homemaking services, mental health and substance abuse screening and treatment referrals, employment and vocational services, transportation assistance, and SSI or SSD application and appeal support.

New York City residents living with HIV are eligible for case management from HASA regardless of income. Eligibility for other benefits requires meeting New York State mandated eligibility criteria. Currently, HASA serves over 33,000 households, totaling over 42,000 people. For individuals requiring housing assistance, HASA offers a wide array of housing options, including temporary housing, supportive housing, and rental assistance.

Over 21,000 households receive rental assistance, allowing them to reside in private market apartments. Additionally, there are 5,500 units of HASA supportive housing.

With regard to temporary housing, HASA offers same-day placements into emergency or transitional housing. Transitional housing provides, transitional housing providers conduct comprehensive assessments

upon enrollment and link clients to support services depending on client needs.

For permanent housing, there are a number of criteria that guide eligibility. For HASA-specific supportive housing, priority is given to clients experiencing homelessness and those who require assistance with activities of daily living, ADL, due to mental illness or substance use. And ADLs are defined as fundamental skills required to independently care for oneself, such as eating, bathing, and mobility.

HASA also works to connect clients with alternate pathways to supportive housing depending on the circumstances of the individual case, including New York, New York, the New York City 1515 Supportive Housing Initiative, the Empire State Supported Housing Initiative, otherwise known as ESHI, and the U.S. Department of Housing and Urban Development's Veterans Affairs Supportive Housing Program, otherwise known as VASH. These programs have their own eligibility requirements.

Those eligibility criteria are in keeping with supportive housing's aims of providing permanent, affordable housing for individuals and families who

experience long-term homelessness and who have varied needs, including complex behavioral and medical needs.

HASA works closely with partners within HRA and sister city and state agencies and with the advocate community as we collectively continue to strive towards ending the HIV epidemic in New York by promoting access to care, education, and support services. We understand the evidence proving housing is a key social determinant of health, that housing as a healthcare approach informs our work and contributes to the important progress that we've made.

The Community Health Advisory and Information Network, CHAIN, is an initiative of Columbia University and the Mailman School of Public Health that has been interviewing people living with HIV-AIDS since 1994.

In a briefing report focused on HASA published in September 2024, focusing on the years 2015 to 2021, researchers found rates of problem resolution and satisfaction with food and grocery assistance are higher amongst respondents who sought assistance from HASA compared to non-HASA service providers. Three-

fourths of HASA clients reported being very satisfied with the housing assistance they received.

Those who reported HASA helped them find stable housing were more likely to have access to stable housing within 18 months, 63%, compared with respondents who reported help by a non-HASA agency, 51%, and respondents who found housing with no agency assistance, 57%.

Respondents who were HASA clients had higher odds of engaging in HIV care that met clinical practice standards with regard to recommended visits, tests, and treatments, as well as higher odds of being adherent to their HIV antiretroviral medication ARV regimen, controlling for a range of client characteristics and service needs.

The New York City Department of Health and Mental Hygiene reported in the 2023 HIV-AIDS, 2023 HIV Surveillance Annual Report published in December 2024, when comparing key 2014 and 2023 metrics on HIV-AIDS, we have made important progress.

In 2014, 85% of people with HIV in New York City were receiving HIV medical care, 81% of whom were virally suppressed, meaning they had undetectable viral load on the last viral load measurement of the

year. People who have HIV who are on treatment and maintain undetectable viral load cannot transmit HIV through sex. In 2023, 88% of people with HIV in New York City were receiving HIV medical care, and 89% of whom were virally suppressed.

The CHAIN briefing report and the New York City Department of Health HIV Surveillance Annual Report underscore the importance of stable housing and social services in delivering positive public health outcomes, working in partnership across DSS to connect clients with benefits and services they need, and our ongoing focus on holistic approach to assisting our clients.

Now, I would like to briefly discuss a recent introduction by Councilmember Schulman, the pre-considered Introduction T-2025-3096, also known as HASA for All.

In 2026, the New York City Department of Health confirmed that clinical symptomatic HIV illness criteria is no longer utilized. As a result, in August 2016, HASA expanded its eligibility to include all persons with HIV, not just those who are symptomatic or diagnosed with AIDS. The pre-considered introduction will ensure that HASA

eligibility expansion is codified in local law. That codification of HASA for All will send a strong message that while the epidemic is changing, so many localities are rolling back on their support with this vulnerable population.

In New York City, we believe that our work is not done. In 2023, 1,686 people were diagnosed with HIV in New York City, with Black and Latino New Yorkers accounting for 83% of new diagnoses. The striking disparity in diagnoses among Black and Latino New Yorkers demands our attention, and these vulnerable New Yorkers are deserving of HASA's lifesaving benefits, as well as continue to work toward an end to the epidemic.

To that end, HASA has pursued recruitment and staff retention efforts vigorously. We have attended job fairs and recruitment events. We have hired more than 146 caseworkers in the last 18 months.

In addition, we have worked with DC37 to implement a retention bonus for our caseworkers. In a constrained fiscal environment, DSS received a hiring freeze exemption for HASA caseworkers. That exemption allowed us to continue our recruitment

efforts and bring on board staff to support our clients.

We acknowledge the ongoing challenge caseworker ratios represent. Hiring in this area represents obstacles given the tight market for people with the skills and expertise who can serve our clients best. We want to take a moment now to show a recruitment video that DSS created that helped us hire the many staff that we have in the last 18 months.

So, as we wait for the video, I'll continue with the testimony, and then we can skip back to it. While we continue to mobilize to recruit and retain HASA staff that delivers for our clients, we have focused on fostering team-oriented case management approach that works. This is an approach that supports our clients and delivers services, resources, and referrals they need.

As our HASA quarterly performance reports demonstrate, case managers and supervisors working in collaborative fashion means decisions on cases and benefits delivered to clients in a line with our goals of timeliness.

Before I close, I would like to take a moment to recognize the resilience, the partnership, and the

leadership of people living with HIV. I would also like to recognize the work of advocates, our staff, fellow public servants, and countless families, friends, and neighbors throughout our communities open whose shoulders we all stand.

HASA today is a product of our city's four-decade commitment. We appreciate the council's ongoing partnership in this work and the opportunity to testify today. We welcome your questions.

Thank you.

VIDEO:

Do you want a job with a purpose? Are you looking to have a job that has an impact on others? Join the New York City Department of Social Services. Work for HASA as a case worker.

Hello, my name is Alvaro Zapata. I'm from Colombia. I work for HRA as a case manager.

Right now, what we do is to prevent homelessness for people who doesn't have the opportunity to try to get everything that they need. And it's, for us, very important to work for them every single day.

I used to be a psychologist in my native country.

Right now, I'm doing part of my job right here. Not as a psychologist, but I'm doing social work.

Really good things about our job is-- that it's something that we do with the soul because you know that you're helping others.

And it's one of the most important things that you got to have if you want to be part of this kind of job. To work for the community, to try to make everybody happy. It's a big work, but if you do it good, everything is going to be good.

When you have the passion for your work and to try to help others doing your job, it's going to be easier. And for all these people, as I say this, when they don't speak the language, it's like a friendly hand that is giving support to them for everything they need.

One of the nicest thing that one of my clients told me once was he was waiting for someone like me.

That's mean that I'm doing a good job right now.

If you want to be part of this job, it doesn't matter your age. If you have your degree or if you have experience, and if you like to work for the community, it's your opportunity because this job is for everybody who wants to be part of this great team in Human Resources Administration.

[END VIDEO]

CHAIRPERSON AYALA: Okay. Thank you. I want to recognize that we've also been joined by Councilmembers Zhuang, Banks, and De La Rosa.

Thank you. Can you tell us what the process is from referral to application to benefits receipt for HASA clients?

MR. ROJAS: Sure. So, in order to be enrolled in a HASA program, you need to demonstrate proof of HIV status and that requires you showing medical documentation, either a signed letter from a physician or a referral form that HASA uses.

Once that's submitted to us, we verify the HIV status with the clinician that signed the form. And then you're enrolled in the program. And once you're HASA, you're always HASA.

So, that means if you leave the program, you move out of state, you move out of the New York City area, or just leave the program, you could come back in and there's no need to again demonstrate your eligibility because you've already established eligibility. If you-- Once enrolled, you will be assigned a caseworker and that caseworker will assist you with determining and assessing the needs that you need. If you are eligible and qualify for benefits, we will assist you in processing cash assistance, SNAP and Medicaid.

And then also assess what other needs you may have. You may need mental health services, you may need substance use referral services, homemaking, home care, and that assessment will assist you in deciding how we triage and refer you for other services.

We also assess your housing situation. If you're homeless, we do a housing assessment and a housing application and refer you to appropriate housing options. And if you're permanently housed and need rental assistance, we assist you with getting shelter allowance to pay your ongoing rent.

CHAIRPERSON AYALA: What is the average caseload per worker?

MR. ROJAS: Currently, the average caseload is about 48 to one.

CHAIRPERSON AYALA: Wow, that's a lot. Is that because of the decrease in staffing ratios?

MR. ROJAS: So yeah, so as I stated in my testimony, we've hired over 140 caseworkers in the last 18 months. We have about an additional 60 plus workers to hire and we're currently in the process of recruiting those vacancies as well.

CHAIRPERSON AYALA: Okay, yeah, that's-- I did case assistance in them. It's a lot of cases, and they require a lot of very detailed, you know, a specific type of service. What outreach does HRA undertake to ensure that people are aware of the HASA program and their eligibility?

DEPUTY COMMISSIONER DUDLEY: Yes, good morning. The HASA program has listings on the public-facing internet that explains what the HASA program is about. It also has an FAQ that lists all the benefits that you may be entitled to and explains how you go about applying. And we also have an advisory board that has members, some appointed by city

council, and that we also use to talk about the program and what we offer and changes and updates in the program.

CHAIRPERSON AYALA: Are you doing any outreach to social service programs in, you know, different communities to ensure that people that may not have access to the internet are able to still have access to this information?

DEPUTY COMMISSIONER DUDLEY: Yes, our service line, which is our word for intake, it's like our public-facing part of the program. They're located at 408th Avenue and our service line staff, particularly our director of service line, has an ongoing linkage to many of our community-based organizations, our hospitals. We also have linkages, quite frankly, to corrections at the state and local level so that people who are being discharged or released from corrections can be, we can make arrangements to have them made eligible for HASA even prior to release so if they're being discharged from a hospital or a nursing home, we try to make sure that they're linked with HASA prior to discharge and if they need housing, if they need home care, we try

to make those arrangements prior to discharge from those type of facilities.

So, we do try to keep linkages to our community-based organizations we meet with on a regular basis and also to hospitals, nursing homes, and other agencies that might want to have clients who they want to link with HASA prior to the person entering the community.

CHAIRPERSON AYALA: Do you know which is your biggest referral source?

DEPUTY COMMISSIONER DUDLEY: I would say at this time, it's probably community-based organizations but also we get a lot from hospitals, from people who are, you know, have been diagnosed and about to be discharged, and maybe they may need housing or home care and so they connect with us as part of their discharge planning. To say, you know, we get social workers contacting us directly at service line.

CHAIRPERSON AYALA: I mean, we've mentioned this a couple of times during my testimony and Councilmember-- Chair, Schulman's testimony that there is an aging population. How does HASA support the specific needs of the older adult community, you know, including accessibility, mobility, and so on?

MR. ROJAS: That's a great question and thank you for that. I think one of the ways we best do that is ensuring our clients are accessing medical care.

So, when they're seeing their HIV specialist, they're not only treating their HIV, they're also addressing any other comorbid conditions that they may have, any other clinical conditions that they may have. So, we routinely ask during home visits or during telephone contacts, are you seeing your medical provider, specifically for HIV but at the same time, are you addressing your other health needs?

So, by ensuring an individual is accessing medical care, they're, and particularly HIV medical care, they're also getting a holistic screening of all their other needs. We work closely with our colleagues at the Department of Health, and particularly Dr. Braunstein's team to-- on a routine, semi-annual basis, see how many of our clients are being engaged in care and how many are virally suppressed.

And then there's a specific focus on those individuals if they're not accessing care or virally suppressed, which allows us to really target it and

say, hey, you haven't seen a medical provider. Why is that? What is the barrier? Or what's going on? Or if you're not virally suppressed, are you having challenges taking your ART medication? So, that collaboration with Dr. Braunstein and her team really affords us the opportunity to do hyper micro targeting of our clients who are not engaged in care and make sure that they do get engaged in care or at least support them. It ultimates their decision.

CHAIRPERSON AYALA: Yeah. Do we know what the percentage of older adults or people that would be considered over the age?

MR. ROJAS: Sure. I'm going to be careful on this because I'm a man of a certain age, but I would say, and if I remember correctly, Jackie, I would say at least 50% of our clients are over the age of 50.

And I would, if I remember correctly, I think at least, I would say at least 30 to 40% of our clients have been with HASA for more than 20 years.

CHAIRPERSON AYALA: Wow.

MR. ROJAS: So, we do have a lot of long-term survival, which is great, which really demonstrate the longevity of our clients on ART medication and

accessing medical care and medical treatment and medication.

CHAIRPERSON AYALA: We've been joined by Councilmember Menin.

In the supportive housing, the HASA supportive housing programs, are there social workers that are trained specifically to work with the elderly population? I mean, because they do have specific needs, right? And I mean, I worked in a senior center and there was a lot of mental health issues, right?, that were going unaddressed. There were not only food insecurity, but maybe dementia, right, that was undiagnosed. Difficulty with mobility, opening a window, changing a light bulb. Like these are things that we take for granted, but that impact the older adult community. Like are those programs--

MR. ROJAS: Absolutely, Councilmember. I think one of the important aspects of our supportive housing programs, and not just the HIV specific ones, but particularly the ones that HASA targets and funds. We have a low case worker-- case manager to client ratio. It's 20 to one. So, therefore, in addition to the HASA case worker that's engaging with the person with HIV-AIDS, they have someone on site,

if it's a congregate facility, who will meet with them either weekly or monthly and assess their needs.

And that includes assessing what medical needs just beyond HIV as well, what are their general needs. And then the good part about that is they coordinate with the HASA case worker. If an individual who is older needs, for example, home care or homemaking, that service can be coordinated through HASA directly, it doesn't have to go to another area.

One of the divisions I also oversee is Medicaid and home care. So, we have a coordination directly at HASA to coordinate for the provision of home care and homemaking services directly. So, we could bypass a lot of that red tape to really enable someone to access additional assistance if they need it in their home.

CHAIRPERSON AYALA: I appreciate that. Can you tell us what the current transportation and nutritional allowance is? And when was the last time that it was increased?

MR. ROJAS: Sure, the current nutrition and transportation allowance is $158 a month. And this allowance has not changed since its inception.

CHAIRPERSON AYALA: Which was when, 40 years ago?

MR. ROJAS: 40 years ago or so, so yes.

CHAIRPERSON AYALA: Well, that's disappointing. I mean, especially because the rate of everything has gone up significantly.

Okay. According to, well-- but before I move on, is that an ask on, you know, now that we're going to be negotiating the budget, would you normally submit a request to increase that amount?

MR. ROJAS: So, that would have to be a conversation with our state oversight agency, the Office of Temporary Disability Assistance, since that is part of a cash assistance allowance. So, that would be a conversation we would need to have with OTDA, and we've had that conversation.

CHAIRPERSON AYALA: You've had that conversation. Okay.

MR. ROJAS: So, something we'll follow up with our team to make sure what the status is and give an update.

CHAIRPERSON AYALA: Yeah, no, I always ask because I find that a lot of agencies have, you know, a need for, you know, more funding in a specific area, but then, you know, are not necessarily out

there, right, fighting for that funding. And so it's important that the advocacy comes not only from the council, but from the organization that has, you know, the firsthand experience of, you know, these programs.

According to the DSS quarterly report on HASA, the administration has failed to meet the required case ratios every quarter since 21. DSS shared in a letter to the New York City Council compliance team that a failure to meet the case ratios was due in part to the hiring difficulties.

I know you said that you've hired 140 social workers so far. So, how long, how, when have you started, when were these 140 workers hired?

MR. ROJAS: The 146 case workers?

CHAIRPERSON AYALA: Yes.

MR. ROJAS: So, the 146 were hired between July 1, 2023, through December 31, 2024. During COVID, we-- a lot of folks retired. It was time and also not coincidentally, and rightfully so, when the last COLAs, staff COLAs were issued, a lot of staff took that opportunity also to retire. One of the, I think, and Ms. Dudley could attest this, one of the successes of HASA is that many of our staff, once

they start working at HASA, stay at HASA. They're long-term workers, they're dedicated to their field, they're dedicated to their clients.

And many of them have worked in HASA since its inception, since the 90s. So, we have a lot of workers who have been on HASA for 30-plus years. So, you know, we are seeing a lot of attrition because of that, and then COVID happened, and I think that accelerated a little more than usual retirements.

CHAIRPERSON AYALA: So, we hired 146 social workers. How many social workers would you need to be, you know?

MR. ROJAS: We are recruiting for an additional 64 case workers.

CHAIRPERSON AYALA: 64?

MR. ROJAS: Correct.

CHAIRPERSON AYALA: Are you recruiting in some of the schools, maybe, as well?

MR. ROJAS: We are, and we have tons of outreach that we're doing provisionally. I think one of the real tools that we've utilized is the fact that we received an exemption to the hiring freeze for case workers, which really gave us the opportunity to hire freely. And during this time, DCATS didn't have an

established list, so we were able to hire provisionally.

So, those 146 case workers are hired. Now, we recently had a civil service exam, and I'm happy to report that I think it was between 98% to 99% of all our provisional staff took the exam and passed it.

CHAIRPERSON AYALA: Oh, that's wonderful.

MR. ROJAS: Yeah, so we'll be able to retain them when later this year, the DCATS list. So, we're working closely with DCATS on-- Because that's important, because if they were provisional and they can't stay, it would be problematic for us.

So, that, coupled with our collaboration with DCATS for the retention bonus, I think has really worked to really hire staff and be able to retain staff, because if they stay X number of months to get that retention bonus, and we also highlight upcoming COLAs, such as in May, there'll be an additional COLA for staff as well, under DC37.

So, I think we have a good plan, and we'll be able to recruit, and we anticipate a DCATS civil service list coming out probably in the spring. I don't want to quote for DCATS, but I think sometime in the early spring.

So, we'll be able to call civil service lists to fill those remaining lines that we have vacant.

CHAIRPERSON AYALA: And will filling those remaining lines reduce the caseload ratio?

MR. ROJAS: Absolutely, absolutely.

CHAIRPERSON AYALA: What would ideally be the average?

MR. ROJA: Well, so the local law is 34-to-one. One thing I would add is that in addition to the caseworkers that we have, anyone who's in supportive housing also has a caseworker.

So, we have about 5,500 units of contracted supportive housing, both congregate and scattered site. In addition to HASA caseworkers, individuals living in supportive housing have an additional caseworker. And those caseworkers that we just spoke about have a 20-to-one caseload ratio.

So, that affords our HASA clients living in supportive housing to access a HASA caseworker in addition to the supportive housing caseworker. And then, you know, we're not even including a lot of the case management services that are available in the community. Through Dr. Braunstein's area in DOHMH, under Ryan White Part A, there is medical care

coordination, medical case management, which is a form of case management for individuals who really need services to help them engage in medical care.

And that's affiliated with hospitals and Dr. Braunstein could talk about that if necessary. So, those are services that are out there and available and there is substantial funding for that and spread across the city. So, there's a lot of services available to our clients, both community-based through HASA and through supportive housing if they're enrolled in a supportive housing program.

CHAIRPERSON AYALA: Okay. While talking about supportive housing. Can you tell us what the current number of homeless HASA clients actively seeking housing is?

MR. ROJAS: Sure. Currently, we have 2,186 individuals residing in temporary housing. And there's two types of temporary housing that HASA provides. One is emergency housing, also known as congregate housing, and transitional housing. And I believe, Ms. Dudley, we have about 1,000 or so individuals who have active housing applications.

DEPUTY COMMISSIONER DUDLEY: Yes. We work with all of our clients who are living in emergency

housing to assist them in getting permanently placed. So, all 2,000 plus, but currently, right now, we have approximately 1,100 who have an active supportive housing application pending.

CHAIRPERSON AYALA: Okay. And how temporary is temporary in temporary housing?

DEPUTY COMMISSIONER DUDLEY: About 150 days on average.

CHAIRPERSON AYALA: Okay.

MR. ROJAS: So, that's a great point, Ms. Dudley. I would just clarify, the average stay is, but no one gets moved out if they don't reach the 150 days. That means, on average, it takes them about 150 days for them to find permanent housing.

CHAIRPERSON AYALA: Okay. And how many of HASA's contracted supportive housing units are currently vacant?

MR. ROJAS: Sure. So, of our supportive housing portfolio, we have-- Sorry, I have that information right here. We have about 8% or 400 that are currently vacant. And we have another 8% that are currently offline.

Offline units are units that are usually-- if it's a scattered site apartment, meaning an apartment

in a community-based, a regular apartment building in a community, may not be leased, they lost a lease or they're transitioning a lease. It may be that the unit is sealed. If someone passed away or there was a NYPD or a fire incident, the apartment will be sealed, and then it has to be opened by a court order.

And then finally, apartments that require repairs or renovations. So, for offline units, we have about 8%, and then we have 8% that are vacant, which is, we range usually between to 5% to 10% because people turn over, people come in, people come out. And that's not always a bad thing because we want some turnover.

So, for new people to come in and other people successfully transition out of supportive housing into independent living, which is a nice cycle for them to move out if necessary.

CHAIRPERSON AYALA: For the units that need repairs, who's responsible for that? The landlord, the sponsoring organization, is that you?

MR. ROJAS: So, it's a mixed bag between the landlord and the sponsoring organization. If it's a congregate facility, it's usually the owner of the

building, it's usually the property management company that's working with the nonprofit for the congregate facility.

If it's in a community-based apartment or what we call scattered site, it would be the landlord of the apartment. So, the nonprofit would have to collaborate and liaise with the landlord to have the repairs made.

CHAIRPERSON AYALA: And that usually takes how long?

MR. ROJAS: That could range. I would say usually 30 days. If it's more extensive repairs, it may be a little longer. Sometimes it takes a little longer.

On occasion, we have client incidents. It might be client-induced incidents or it might be a fire or it might be a flood, what have you. So, those take a little longer.

CHAIRPERSON AYALA: Fair enough. Moving on to the funding. So, HASA's budget for fiscal year 2025 is currently almost $300 million and has been baselined at about $282 million for fiscal year 26 and the out years.

The funding for the program varies with about 50% coming from the city, 26% from the federal government, and 22% from the state.

In light of the Trump administration's recent efforts to cut federal funding, there is a very real chance that the federal funding source will go away. What plans does the city have to ensure that individuals receiving care through HASA will have continued access to services and housing, and to fill the funding gap that will be left if the federal government stops the spending?

MR. ROJAS: So, as you stated, Councilmember, 26% of our funding is federal-based. I would say a large part of that is through a collaborative grant with the Department of Health and Mental Hygiene under Dr. Braunstein's team.

We're monitoring our federal funding closely to see if there are any changes. We don't anticipate any changes to our shelter allowance.

We continue to provide rental assistance to over 21,000 individuals. That hasn't changed, and we don't anticipate that will change. We continue to do so.

CHAIRPERSON AYALA: And-- oh, sorry. I want to recognize that we've been joined by Councilmember Riley.

In the HASA quarterly performance report for July through September of 24, there are 44 cases listed as ineligible due to not meeting medical criteria.

Can you share if these applications were from individuals who did not have an HIV diagnosis, or were there different medical criteria that they did not meet?

DEPUTY COMMISSIONER DUDLEY: Yes, these are individuals who, the only medical criteria you need to meet to become a HASA client is to be HIV positive. But these are people who, unfortunately, were not able to submit sufficient documentation to establish the fact that they were diagnosed with HIV.

We offer assistance where necessary and with the proper authorization from the client, we will help them in contacting their doctor and getting the lab reports if necessary.

But, unfortunately, for those individuals, they weren't able to do so, but they're always welcome to come back at a later time and submit the proper

documentation, and we will definitely reconsider those applications.

CHAIRPERSON AYALA: Okay. And there were 1,198 cases that were closed during that same reporting period. Of these, 405, or 33%, were closed due to failure to recertify. What is the recertification process for HASA cases, and what outreach is done to ensure that clients are aware of the need to recertify and can do so in a timely manner?

DEPUTY COMMISSIONER DUDLEY: Well, in HASA, one of the good things that in our program, we don't have automatic case closings for failure to recertify. If a client does not recertify in a timely fashion, and they're sent out mail notifications by mail to notify them of their recertification date, we also-- because we have case management staff, we also make phone calls to the client to remind them that, "Hey, your case is going to close, you need to come in and recertify." But sometimes clients, unbeknownst to us, they may have relocated to another jurisdiction or something else may be going on that doesn't allow them to complete their recertification, but it's not automatically closed by a computer at a certain date. We conduct outreach.

But certainly at a certain point, if we continue to be unsuccessful, by state law, we have to close those cases, but if they reappear and show up at any time, we can certainly work with them to reopen those cases.

CHAIRPERSON AYALA: Well, 333 cases were closed due to excessive income, of which 84 were for excess income with Social Security.

Do you know how many of these cases had excess income of less than $5 or less, or above the income requirement?

MR. ROJAS: We have, our team is crunching those numbers. I can say that in recent years, and in particular, I believe two years ago, all individuals receiving Social Security were fortunate to have larger than usual increases. Actually, I believe in one year, it was over 8%.

Unfortunately, that does-- when income does increase, it may make you ineligible for cash assistance based on your income, but we are crunching those numbers for those 84, and we'll formally respond with a breakdown at the levels you pushed by, the five, the ten.

CHAIRPERSON AYALA: Okay, is DSS able to request a waiver for clients with minimal excess income?

MR. ROJAS: No, DSS is not able to request waivers for cash assistance clients, including HASA clients.

CHAIRPERSON AYALA: Okay, I'm going to stop asking questions now, because I have a lot of colleagues here, and I want to make sure that they have an opportunity to ask.

I'll turn it over to the Chair, Schulman.

CHAIRPERSON SCHULMAN: Thank you very much, Chair Ayala.

So, I just wanted to go back quickly to, when we spoke about outreach for HRA, for the HASA program, do you also work with the city's public engagement unit?

MR. ROJAS: Yes, we work with PEU. I would also say that in addition to the outreach efforts that Ms. Dudley described, we have a-- in addition to the advisory board, we have a HASA working group, which includes consumers, advocates, we have a lot of attorneys on as well, representatives, where we talk about HASA services, and we have over 100 contracted providers that provide primarily housing services,

but those housing providers are also providers of community-based services, not housing. So, we have a wide array of housing and non-housing providers that we connect with regularly.

So, yeah, and it includes our public engagement unit, PEU, as we know it.

CHAIRPERSON SCHULMAN: Because my understanding of, when I was doing some work with them, they go door-to-door, which is great. So, you know, which is very helpful. Okay, I'm going to ask now some DOHMH questions.

So, one question that I had-- So one of my colleagues, Councilmember Narcisse, asked me, and I have the same question: what is attributable to the increase in HIV-AIDS cases, if you can respond to that?

DR. BRAUNSTEIN: Sure, thank you for that question, Councilmember. So, we did, yes, as noted earlier in your comments, we did note a 7.6% increase in the number of new diagnoses we saw in the city between 2022 and 2023.

We do-- You know, surveillance data are incredibly powerful, but don't tell us lots of the why.

But, you know, our speculation and what we've observed in other recent years is that there's likely a contribution to this increase of people returning to engage in medical care and sexual health care, specifically HIV testing, you know, either because of an absence from healthcare during and post the height of the COVID-19 public health emergency, and then returning to sexual health care since.

CHAIRPERSON SCHULMAN: Great, no, I appreciate that, and not necessarily a question for you here, because I have another hearing next week about public health emergencies, which will include HIV and AIDS, but I think we need to take a look at how we collect the data, considering what's going on with the federal government right now, and how we're going to move forward with that. So, I'm just putting it out there, I'm not...

So, to conduct the report, DOHMH states that they rely on electronically reported HIV-related laboratory tests, and DOHMH-led investigations that confirm the date and fact of an HIV diagnosis. How does DOHMH conduct these investigations?

DR. BRAUNSTEIN: Sure, so we are fortunate to have a very robust case investigation team and

program within the Department of Health and Mental Hygiene, wherein we, as you noted, we receive electronically reported laboratory tests indicating HIV positivity, and then actually, while someone is living with HIV, we also receive all tests related to their HIV, so CD4 counts, viral load tests, that enable us to measure and track outcomes for people living with HIV. So, we receive those laboratory tests, house them in a very secure, very sophisticated data system, our surveillance system, and then we have a team of community-based staff who use that information on someone's first positive test reported to the health department to approach that person for interview, and that interview has multiple purposes, two primary ones being to ask that person about sex or needle-sharing partners that may have been exposed to HIV and could benefit from HIV testing, linkage to care if positive, or HIV prevention, such as pre-exposure prophylaxis, and also then to link the newly diagnosed individual with HIV medical care.

So, we-- And we do reach nearly all people diagnosed with HIV in a given year.

CHAIRPERSON SCHULMAN: I was going to ask you also, what is DOHMH's process of searching for unreported cases? And by the way, with everything going on with the federal government, there may be more of those, so...

DR. BRAUNSTEIN: Sure, we, you know, we have a very close relationship with, you know, the providers throughout New York City, so there's a sort of duplicative-but-complementary system wherein not only are we receiving laboratory tests related to HIV automatically, electronically to our surveillance system, but also providers report new HIV diagnoses that they've made and also are required by law to report people who are diagnosed with HIV who are new to their care.

So, we have multiple sort of checks and balances. So, that's-- You know, provider reporting is a critical way that we learn about perhaps not as yet reported HIV positive people through our surveillance system.

CHAIRPERSON SCHULMAN: In your 2023 annual report, you noted a 7.6% increase in the number of HIV diagnoses in New York City from 2022 to 2023, but a 17% decrease in new HIV infections. One is how did

you determine there had been a 17% decrease in new HIV infections despite the increase in diagnoses, and can you explain the divergence in the two statistics?

DR. BRAUNSTEIN: Sure, thank you for that question. So, yes, so HIV diagnoses are actual first positive tests reported to our surveillance system as I just noted. HIV incidents, which is actually the number of newly acquired infections during a period of time. These are not necessarily diagnosed and so are not, you know, known through a positive test.

So, instead we and other health department jurisdictions across the country estimate HIV incidents using a methodology, an analytic methodology developed by the Centers for Disease Control and Prevention. And that methodology uses CD4 count or a marker of immune status data that we do get in surveillance to essentially estimate among people reported to the surveillance system when they may have acquired their HIV infection. And that number is really powerful because it gives us a better sense even than the number of new diagnoses of the sort of leading edge, the current, you know, even more complete status of HIV acquisition in the city in a given year.

So, you're right to point out that we did see this divergence in a single year between the number of new diagnoses and the estimated number of HIV infections. And what we, you know-- No one year, no one data point makes a trend. So, this is something we'll certainly monitor over time to see what direction this takes.

But what we, you know, hypothesize around these two numbers together is that that new diagnosis number reflects that we did in fact importantly detect more people who had been living with an HIV infection for a longer period but were not yet diagnosed. And that it looks like so far that the actual number, estimated number of people acquiring HIV is going down.

CHAIRPERSON SCHULMAN: Okay, thank you. So, the annual report also states that the highest number of deaths associated with HIV-AIDS occurred among black and Latino, Hispanic New Yorkers who are based, who are based poverty levels were classified as medium poverty or very high poverty. How is DOHMH ensuring valuable information and resources regarding HIV and AIDS are getting to those communities who most need it?

DR. BRAUNSTEIN: Yeah, absolutely. Our, the entire suite of our programming, both on the prevention side and on the care and treatment side is all driven by what we know to be the epidemiology of HIV and the disproportionate distribution of HIV in this city.

So, we specifically work with clinical institutions, community-based organizations based in high-poverty or high-prevalence neighborhoods and areas or who serve clients living in those areas to ensure that our resources, both prevention and care and treatment, are targeted to the people who need them most.

CHAIRPERSON SCHULMAN: Okay, according to DOHMH, the Ryan White HIV-AIDS Program, Part A Grant Awards Program, provides an expanded form of HIV case management along with temporary housing support. How many units of supportive housing are available under that program?

DR. BRAUNSTEIN: Sure, so we measure the reach of the Ryan White Housing Program more so in number of active clients enrolled in a given year. And so in grant year 2023, which is the most recent complete year of data available, we served a total of 416

clients for short term housing programs. We served a total number of 415 unique clients for housing placement assistant programs, and 221 clients received short term rental assistance through the program.

CHAIRPERSON SCHULMAN: So, DOHMH receives the Ryan White Part A Grant from the federal government to provide services to individuals living with HIV in New York City.

In 2024, New York City received a $92 million grant for the program. In 2024, New York City also received a $45 million formula grant from HUD for the HOPWA program. In light of the Trump administration's recent efforts to cut federal spending, there's a very real chance that this funding stream will go away.

What plans does DOHMH have, if any, to ensure that individuals under these programs will have continued access to services and housing if federal funding disappears?

DR. BRAUNSTEIN: It is true that this critical work to support people with HIV in the city is largely reliant on federal funding. And these are large grants that DOHMH has received over many, many

years. And we are very closely monitoring the situation, working with national partnerships and health department colleagues across the United States to really monitor the situation very closely in terms of future funding levels.

Are there any DOHMH-- We heard from the folks at DSS-- Are there any DOHMH HIV-AIDS programs or services geared towards older New Yorkers on your end?

DR. BRAUNSTEIN: Yes, absolutely. Including as part of our Ryan White Part A program, we have a number of partnerships that we support, that we fund through that program with clinical institutions to provide ambulatory and other wraparound care services to people aging with HIV. So, typically people ages 50 and older. We have-- Yeah, we have a number of programs dedicated to serving people with HIV who are aging.

CHAIRPERSON SCHULMAN: So, now I'm going to ask you to describe how you guys work together so that you don't have overlap and that you are working efficiently in this space because that's going to be important moving forward, obviously.

DR. BRAUNSTEIN: Yeah, my colleague mentioned a really robust collaboration that in fact has been such in existence since 2007.

So, the team that I mentioned that's under my bureau that goes out and does partner services interviews and links people newly diagnosed with care also has a component to its work to use our surveillance data to identify people …who may be disengaged from HIV care and to proactively do outreach to those people to facilitate their relinkage to care. We twice a year, as John mentioned, we twice a year do matches with the data matches with the HASA client list to very pointedly assess the care status and viral suppression status of HASA clients and then those who appear to not be engaged in care, my team will go out and facilitate relinkage to care.

I will also note that because not only is HIV under my purview in the Bureau of Hepatitis HIV and STIs but also STIs and viral hepatitis are. We not only match the HASA client list to our HIV registry to identify those clients' HIV care status but also look at our STI and viral hepatitis surveillance systems to see if those clients additionally need

support for linkage to viral hepatitis, B or C, care and treatment or screening and STI treatment as well.

So, it's a really robust collaboration.

I will also note just in terms of the conversation earlier that because of that collaboration, my team also and we are often, especially from the health department perspective, the first people interfacing with someone newly diagnosed with HIV. And so we do a very broad assessment of need for supportive services broadly beyond just HIV itself for those people including promoting the HASA program.

So, it's really a really important sort of touch point for people being newly diagnosed with HIV to make them aware of the HASA program and direct them to these colleagues.

CHAIRPERSON SCHULMAN: Do you-- So do you have a-- Because I know we heard testimony earlier about my pre-considered intro. Do you have a position on that or...?

DR. BRAUNSTEIN: We don't.

CHAIRPERSON SCHULMAN: To expand the HIV definition for HASA?

DR. BRAUNSTEIN: I think we would support our colleagues' position. Now I want to thank you and I also want to say that especially in light of everything that's going on, one, we want to make sure that HIV, people living with HIV and AIDS are taken care of but also to the extent that you can promote that and let people know that we're here for them and with everything that's going on, that would be much appreciated. So, thank you.

Chair Ayala, I'll give it back to you.

MR. ROJAS: Councilmember, I would also add one, I think critical collaboration that I think really saved lives in the last couple of years was our collaboration on COVID. The Department of Health, through Dr. Braunstein's team and other areas, other divisions, the Bureau of Communicable Diseases, Bureau of Immunization and their emergency response teams really collaborated with us in our congregate facilities, in our temporary housing, SRO, emergency housing transitional facilities and our permanent supportive housing.

We were able to scale up testing onsite at all our HIV housing facilities, both emergency and permanent and congregate settings. And when

necessary, we were able to place folks in isolation and quarantine, provide them access to resources if they needed treatment in addition to what they were receiving from the general medical care.

The guidance that the providers really, really, really saved lives.

And similarly, during that same time as we were tackling COVID, we had an overlay of monkeypox that Dr. Braunstein's team and others and the Department of Health really helped us with. So, we were literally in a collaboration where we had HASA case workers, nights and weekends, calling up staff. We were working with their teams to schedule appointments at their sexual health clinics to do a monkeypox vaccination for this target population since they're more susceptible to-- I'm sorry, mpox, I know it, I apologize. Mpox, not monkeypox. We changed the name.

So, we did that collaboration. I just want to thank my colleagues at Department of Health because it really saved lives and it really gave the most vulnerable or the vulnerable due to clinical needs the access to vaccines for mpox, as well as COVID vaccinations that we were providing. We provided it

onsite, but we coordinated any ancillary care that we needed with our partners at the Department of Health.

CHAIRPERSON SCHULMAN: I just have one quick question. If somebody has HIV and is in need of help, can they call 311 and get referred to you guys? Is that what--

MR. ROJAS: Absolutely, absolutely, yes.

CHAIRPERSON SCHULMAN: Okay. Thank you very much, Chair.

CHAIRPERSON AYALA: Thank you. Councilmember, I'm sorry, Ariola has a question. Thank you, Chairs.

COUNCILMEMBER ARIOLA: So, we've talked a lot about your programming and it really is very robust and I'm impressed with all the work that you're doing, the good work that you're doing. But also we're really focusing a lot on the potential of a lack of federal funding for this type of programming. I know that you said, DOHMH, that you've been in touch with your counterparts on a federal level.

Has there been any indication that funding for DOHMH or for HASA will be done, any defunding of your programming? Do you have any indication from the federal government, the new administration, that that should happen?

MR. ROJAS: At the Department of Social Services, at least to my knowledge, haven't received any formal funding. A large part of the 26% of our federal funding that comes to DSS is actually through a shared grant with the Department of Health. So, it's the same housing grant that we share through HUD.

At least on our end, we haven't received any formal funding of any cuts. But again, both of our agencies sit on national boards and are monitoring closely that. But I haven't received any formal funding, formal notification of any cuts to funding as of yet.

COUNCILMEMBER ARIOLA: All right, thank you so much. And we haven't either. Perfect, thank you so much.

CHAIRPERSON AYALA: I'm going to move to the PMMR indicators for HASA. According to the latest city performance report, in the first four months of fiscal year 25, the average number of days to issue enhanced housing benefits from submission of completed application increased by 39% to 20.9 days. What is the cause of the increase in average days that HASA clients must wait after submission to receive housing benefits?

DEPUTY COMMISSIONER DUDLEY: Thank you for that question. Certainly we strive at the HASA program to process all applications as quickly as possible. By law, we have 30 days after an application is completed to issue the benefits if the application is approved. However, during this past summer, the summer of 2024, and early fall, we did have a larger than normal amount of recertifications.

And why did that happen? It was because during the COVID pandemic and shortly thereafter, we had gotten a stay delayed and granted a waiver of recertifications for a lot of clients, so clients could shelter at home. And so recertification dates were pushed out. But what happened was last summer and early fall, the recertification dates and new ones came due.

At the same time, we had our normal recertifications due every month during that time period. So, we had a larger than normal amount of recerts. And the same staff were handling those numbers, were handling the benefit issuances.

So, we just had a larger volume during those months, July, August, September, October. The good news is we're starting to see it level out. And so

we're hoping that our performance will return back to its normal rates.

CHAIRPERSON AYALA: That makes sense. Yeah. The budget for HASA SRO hotels went up substantially between the November fiscal 2025 budget and the preliminary 2026 budget, from $28.6 million to $46.6 million, an $18 million increase.

Can HRA detail what the increases in budgeted funding is for?

MR. ROJAS: Sure. Our budget is, since our SRO emergency housing portfolio is per diem and it's based on need, it's funded at one amount. And as needed, we increased the budget to accommodate additional resources they may need.

So, basically, we don't overfund it because we may not need as many units at that time. But as we monitor it on a daily basis, how many folks are being placed, how many require emergency housing in SROs, and as that number increases or decreases, we adjust the budget. So, as the year goes by, usually we'll see on an annual basis an increase to cover the cost.

Unlike our transitional housing contracts or supportive housing where you have a set contract, you enter into a contract with a person and that contract

is locked in place. For SROs, it's like a hotel. You pay as you reside.

And if nobody's in there, we don't pay you for it. So, as that number fluctuates, we adjust our budget accordingly.

CHAIRPERSON AYALA: How many SRO hotels are you guys using or contracting?

MR. ROJAS: Currently, we have 2,117 units of emergency housing, SRO housing.

CHAIRPERSON AYALA: Okay. Can you tell us what is the budgeted funding for HOSA contracts in fiscal year 26 and in the out years?

MR. ROJAS: Sure. So, I can tell you currently what our, for FY25, currently for supportive housing, we have an annual, the contract value of our supportive housing contracts is $179 million.

We have 98 contracts for roughly about 5,500 units of supportive housing. For transitional housing, we have annual budget of $26 million with 774 contracted units. Okay.

CHAIRPERSON AYALA: Are all 78 contracts for direct HOSA services for HRA clients?

MR. ROJAS: For our housing, it is solely for HOSA clients.

CHAIRPERSON AYALA: Okay. Okay. I have no further questions. Seeing that there are no other questions from the panel, from the members, then that concludes this part of the hearing. Thank you so much for coming.

MR. ROJAS: Thank you.

CHAIRPERSON AYALA: I want to recognize that we've been joined by Councilmember Stevens.

I now open the hearing for public testimony.

I remind members of the public that this is a government proceeding and that the quorum shall be observed at all times. As such, members of the public shall remain silent at all times. The witness table is reserved for people who wish to testify.

No video recording or photography is allowed from the witness table.

Further, members of the public may not present audio or video recordings as testimony, but may submit transcripts of such recordings to the Sergeant at Arms for inclusion in the hearing record. If you wish to speak at today's hearing, please fill out an appearance card with the Sergeant at Arms and wait to be recognized.

When recognized, you will have two minutes to speak on today's hearing topics. Actually, that's three minutes to speak on today's hearing topic, the administration of HASA. If you have a written statement or additional written testimony that you wish to submit for the record, please provide a copy of that testimony to the Sergeant at Arms.

You may also email testimony to testimony@council.nyc.gov within 72 hours of this hearing. Audio and video recordings will not be accepted. I'm going to be calling the first panel.

Armen Merjian, John Boyle, Daniel Leyva, and Joshua Elmore.

You may begin.

MR. BOYLE: My name is Jack Boyle. I'm a staff attorney with the Neighborhood Defender Service of Harlem. I want to focus specifically on the rental assistance payments administered by HASA. Our office has recently seen numerous HASA recipients who've been brought to housing courts solely due to bureaucratic failures that have significantly reduced or entirely cut off their voucher payments.

We often find that caseworkers are not able to correct these errors in a timely manner. Our clients

frequently report that their assigned caseworkers have expressed personal hostility to them and their status. Yet every time a HASA client interacts with HRA, they're expected to do so only through that assigned caseworker, who's often overworked, creating an unnecessary hurdle to accessing or making necessary changes to benefits.

These challenges mean that HASA clients are often in a more difficult position in housing court than recipients of other HRA voucher programs such as CityFHEPS and StateFHEPS. NDS urges the council and HRA to consider changes to this important program to protect these extremely vulnerable clients.

First, the council should consider changing the administrative code to require reporting on the timeline from when a HASA client first requests that a caseworker begin an application for a benefit to when that application is actually completed.

Currently, reporting is only required from the timeline from when a benefit application is marked complete to when-- or submitted, to when a determination is actually made.

This is concerning as numerous clients report that caseworkers fail to or refuse to actually start those benefits applications or requests entirely.

For example, Mr. Y accrued significant rental arrears as HASA miscalculated his rental assistance payments.

Mr. Y notified his caseworker of the issue over a year ago and repeatedly begged for assistance. No action was taken.

Even when an attorney got involved, it took half a year for HASA to complete a request for the arrears, and even then it did so for an incorrect amount.

Today, Mr. Y remains at serious risk of eviction.

Another client, Mr. Z's partner, was a HASA recipient and a co-tenant in the apartment. When our office applied for a one-shot deal on behalf of the household, HRA refused to process the application and demanded that it go through HASA.

The HASA caseworker then also refused to assist, and the caseworker informed NDS that he did not care about preventing the eviction because HASA preferred to force the tenant to get evicted and enter shelter.

These are just a few examples among many. The extensive advocacy and litigation that is often required to obtain basic assistance from HASA places an unfair burden on clients and advocates alike.

The council and HRA should also consider steps to permit HASA clients to submit their own applications so that access to benefits are not entirely held up by an uncooperative or often overwhelmed caseworker.

Second, HRA must do more to protect HASA clients from discrimination. HASA is the only HRA program where individuals managing a tenant's rental assistance are aware of sensitive medical information like their HIV status.

Indeed, in prior testimony to this council, Commissioner Park explained that HRA does not track the APS status of CityFHEPS recipients precisely for this reason. And if HRA is unwilling to consider disentangling a HASA client's HIV status from their rental assistance case, it must do more to ensure that caseworkers are fully trained to interact with this extremely vulnerable client population.

Lastly, the council and HRA should consider normalizing and simplifying HASA rental assistance. There is no reason why HASA clients should not be

able to provide information externally that explains their housing benefits in the language and format of more well-known programs that do not require recipients to be HIV positive.

We welcome your questions.

CHAIRPERSON AYALA: Thank you.

Tiara? Yes, can you come? Thank you. Sorry, you may begin. You, yeah.

Puedo empezar?

MR. LEYVA: Yeah. Hello. Good morning, everyone. My name is Daniel Leyva. I'm a person living with HIV since 1998. And also, I work, I'm employed by the Latino Commission on Aids, working in prevention, HIV prevention, with the Latino Hispanic community specifically, but with all persons of color.

I'm here in support of the legislation introduced by Councilmember Lynn Schulman because both as a person living with HIV and as a service provider, I have seen how housing can help not only people to stay healthy, but also access other services such as mental health that is very much needed in our city. And also, with the amount of people over 50, that are recently diagnosed with HIV and who are unfortunately

seen in our societies considered unemployable because of age, these services are extremely, extremely important. I did not prepare any remarks because speaking as a person living with HIV, for me, is much more than providing data, but also providing the life experience.

I've seen, in following the priority of needs of Maslow, we have seen how housing remains one of the most important, one of the basic services that will help people achieve not only a healthier life, but we have seen how the decrease of HIV happened in part because of U=U. People living with HIV who are on treatment and become undetectable have a lesser possibility, almost no possibility to transmit HIV. This is possible through offering people the basics of life, so I'm fully in support, again, as a person with HIV and a service provider, to this legislation because it also will impact severely, positively, HIV prevention in our city. Thank you very much.

MR. MERJIAN: Hello everyone, Armen Merjian, Senior Staff Attorney at Housing Works. I and we represent the entire class of HASA clients in a major lawsuit, Henrietta D. versus first Giuliani, then Bloomberg, it went all the way to the Supreme Court.

I want to challenge this body and say that this body has been asleep at the wheel.

I don't say that lightly, but oversight and enforcement have been wholly lacking with regard to HASA.

The question was asked, what is the ideal caseload ratio? There's not an ideal caseload ratio, there is a legally mandated caseload ratio that they're woefully failing to observe, and that is the font of so many of these problems.

We began in 1994 suing over these caseload ratios. They are a ramp-- We call them a ramp for the disabled to gain access to benefits and services. We had to take the Henrietta D. case all the way to the Supreme Court of the United States in which the judge after a long trial declared that HASA was chronically and systematically failing to provide access to critical subsistence benefits with devastating consequences. The judge's word, a Republican Bush-appointed judge nonetheless found that it was woefully inadequate.

We then won a decision which echoed what this chamber had passed. In 1997, this chamber passed Local Law 49. Local Law 49 mandates an overall ratio

of 34-to-1 at HASA and in important family cases, 25-to-1.

After we won the Henrietta D lawsuit, independently, the federal court mandated as its federal order that they maintain a 30-to-1 and 25-to-1 ratio. And that was also extended to every HASA office, not just HASA-wide because otherwise you would have incredible problems where some are observing and some are out of whack. So, there's not an ideal average.

There's literally a doubly legally compounded average that they are failing to observe every single day and they have for years and they've never been called on the mat. They talk about how many folks that they have hired. They didn't tell you how many folks have left through attrition and other things.

The number hired is irrelevant. The only relevant figure is what is the caseload ratio at HASA? Is it 34-to-1 overall, and is it 25-to-1?

Well, as they told you, it's about 48 or 49. And I've been saber rattling to bring a contempt motion.

Just so you know, I twice had to go to court after Henrietta D. after suing Giuliani to back down Mayor Bloomberg who proposed cuts in the budget to

HASA which would have blown up the ratios. Those are illegal. The federal court ordered them not to do it.

When HASA disingenuously tells you that they seek a hiring freeze exemption, it's a lie. It's not something that they have to seek as an exemption. They are legally required by this body and by the federal court, both independently, to meet 34-to-1 and 25-to1. They're not allowed to put a hiring freeze, especially when they're woefully behind.

And so everything flows from it. They've been asking HASA workers to work overtime, nights, weekends. Can you imagine an already difficult job and harried workers and clients being contacted after hours or at night? It's not a solution. And so many of the problems you're going to hear about and you've heard about flow from the fact that these are horribly overworked folks.

It's a workers' rights issue as well. If we can get it down to 34-to-1 and 25-to-1, the workers will not be harried. They will take calls. They will get people their benefits.

And it's a matter of life and death.

So, really, this council needs to engage in oversight and enforcement.

I should also tell you quickly that the question of how long it takes folks to go from the homeless system into permanent housing is an important one for this council as well because HASA has very little housing actually.

The overwhelming majority, tens of thousands of HASA clients go to the private market, like folks do with the CitiFHEPS or Section 8 vouchers. The problem is we have a conflagration of rights in that area because the number one source of housing discrimination in New York is a source of income discrimination, voucher discrimination.

In 2008, this body passed, wonderfully, a source of income protection but with no enforcement and no oversight. And so once again, it's a tree falling in the forest. We at Housing Works have brought probably more of those cases than anyone in the country. We received zero funding for it.

And so what happens is folks are trapped finally in the HASA homeless system because they can't get attorneys to help them and landlords are routinely failing, telling them we don't take vouchers or

imposing illegal minimum income requirements irrelevant for people who don't have any share, for example, of the rent, or doing something called ghosting where they simply find out you have a voucher or subsidy and don't call you back. And the only way to attack that is through testing, paired testing and enforcement through lawsuits.

So, I challenge this body really to get involved in oversight and enforcement, otherwise the rights of the most disadvantaged New Yorkers, multiple disadvantages, right? Overwhelmingly black and brown and poor and unhoused and living with chronic substance use issues with comorbidities galore, everything under the sun. And I've often described just one client and these are the folks that are not getting their benefits and services from HASA because of this wholly, wildly out of whack caseload ratio.

I welcome all your questions.

CHAIRPERSON AYALA: Make sure your mic is on, Mike.

MR. ELMORE: Good morning, Joshua Elmore, he, him. I'm the supervising attorney for Legal Aid Society's HIV-AIDS Representation Project.

We're a citywide civil practice and the bulk of our practice is advocating on clients for clients to receive their legally-entitled-to HASA benefits. What we've seen is really for many of us who've been working with HASA is a deterioration over the years in the quality of services, particularly as many people have noted, clients' abilities to access their caseworkers. Often they don't have assigned caseworkers. Those who do, we're unable to reach them. They're unable to reach them either at their centers. To the extent home visits are happening, they're often unannounced. They don't have a working cell phone. Clients can't leave voice messages.

This is a serious issue and so while much of what HASA said is how in their testimony is how things are supposed to work, in actuality, that's often not the case for our clients.

I do want to specifically respond to a few things that were noticed: The service line. That used to be a public-facing telephone number that clients could reach to enroll, access benefits. That has been rolled into HRA's one number.

So, the only way that clients can, practically speaking, from both client reporting as well as

testing our practice is done, you can no longer access the service line by phone because it's part of HRA's one number. It simply does not work. Clients have to go in person either to their center or to 400 8th Avenue to meet with service line staff.

This obviously puts an additional burden on disabled people who might have difficulties visiting in person, and this used to be a service available to public-facing to HASA recipients.

The 30-day figure was noted as a legally-mandated requirement, often this process is delayed because they will not consider the applications until all documentation is provided by the client. The caseworkers often do not help clients obtain this documentation.

Additionally, clients repeatedly are asked to sign documents that are undated and then the caseworker will date them to indicate 30 days so that they can show that the decision made was in 30 days but those are made-up dates effectively. We've seen this happen consistently, it has happened to advocates at other organizations.

The case-by-case financial assistance is what effectively is a one-shot deal as we refer to it more

in sort of the regular HRA context, and one thing that's challenging we see with HASA recipients is the rental assistance unit as a part of HRA has vastly improved and so you can work directly as an advocate with RAU to get a quick answer for clients who are days away from eviction or are in fact already been evicted.

This is a process that HASA does not take advantage, it regularly takes months whereas the RAU process will take only days. This seriously puts HASA clients at a disadvantage and doesn't allow an advocate-informed process to take place. HASA caseworkers are not aware or often informed around the legal proceedings in housing court so the process is completely disconnected from the legal realities we as advocates face.

And I realize it's time but I do just want to point out one other thing and that is the COLA adjustments.

One real issue that the HASA budgeting has, the way clients are determined to be budgeted is based on their actual rent so a client who has a $1,050 in SSI income and lives in a $1,000 apartment, has been there for decades, will get cut off whereas a client

with $1,050 in income and a $2,500 apartment, HASA will continue to pay so long-term elderly clients are being kicked off due to COLA increases and the only solution for them, the only way they could get re-enrolled as HASA is to move to a more expensive apartment so they lose that benefit due to how HASA budgets, so-- and I'm happy to provide additional information and written testimony. This is a really perverse incentive and troubling as it's not something that happens with CityFHEPS or other programs and it really displaces in most burdens long-term low-rent apartments for elderly long-term HASA recipients.

Thank you.

MS. LABRADA: Hi, my name is Tierra Labrada, I'm the Policy Director for the Supportive Housing Network of New York. I agree with everything that everyone up here just said. You know, the HASA has been a close collaborator with the network for a long time, however, oversight is wholly inadequate and it's made it very difficult to make systemic change and I'm going to get to my testimony.

I want to talk today about the vacancies in supportive housing units. HASA mentioned that they

have about 400 vacancies in their supportive housing units. And I apologize, I wasn't here to hear how long they said that these vacancies have been persistent but from our providers, they have been vacant for a very long time. HASA is supposed to send three referrals per vacant unit, and that is just simply not happening.

One of our providers reported that in December of 2024, they only received 45% of the referrals that they were supposed to receive. They had 22 vacancies and were only able to move two people in. Part of this is due to the way that we have set up our system for their emergency housing.

So, as you probably heard here, HASA transitional housing program does not require clients to pay rent and does not impose any time limits. This is very admirable, right? But what happens is that then we have a system that disincentivizes people from moving from emergency and transitional housing into permanent supportive housing. So, the city is paying for this double.

I'm going a little bit off script here. Let me go to my script.

It's not a housing issue, it's fiscal and moral failure.

Hundreds of units are sitting vacant while providers are losing revenue. So, this one provider that I just mentioned, 45% of referrals, they were expecting 22 vacancies, only moving two people in. They actually lost a federal grant most recently in this year's NOFO because of their occupancy rate, which is about 80% compared to 95% occupancy with their DOHMH contracts.

This means that folks who could gain access to these units are not actually gaining access to these units.

I do have a couple of proposed solutions here, which is to allow HASA-contracted providers to transfer their units to DOHMH units. HASA has consistently told us and providers that they do not have eligible clients in their emergency housing programs that want to move.

That's why they're not sending referrals and folks are not moving into these supportive housing units. We can transfer these units to DOHMH units so that they can serve a broader population while also continuing to prioritize HASA clients. Some of these

units are in SRO units, which we've beat the drum for a very long time about the challenges with filling SRO units, especially for people who are exiting the homeless service system, DHS shelters, HASA transitional housing, moving from one SRO where you don't have to pay rent or you've been stable there for a long time into another SRO where you're required to pay 30% of your limited income on rent.

We would really appreciate the opportunity to consider investing in capital investments to convert these SROs into studio apartments.

Another consideration that we've talked to HASA about is incentivizing folks to move from HASA SROs to permanent supportive housing SROs by capping their tenant contribution at $50, which is something that DHS has done with CityFHEPS. If you're moving into an SRO unit from a DHS shelter, because folks don't want to pay 30% of their limited income to move into an SRO unit.

I also do just want to acknowledge the data transparency issue with HASA. 5,500 units, 1,400 of which are in CAPS, the Coordinated Assessment and Placement System. This system has a report, the Local Law 3 report, which this body actually passed a

couple years ago. It's submitted every year. But 1,400 of those units are actually in CAPS, so they get reported on.

So, we can see the vacancy and referrals that happen for these units, but for 4,500 or so units that are in HASA Web, it's like a black box. We have no data, we have no access to know how many of those units are actually vacant, how many of those referrals are being made, the length of time those units are vacant. We talked a little bit about sealed units. There's no data transparency for HASA and it's really difficult to get them to submit data.

So, I know I'm out of time. I have longer written testimony that outlines all of this here and I'm happy to answer any questions.

CHAIRPERSON AYALA: Yeah, I don't have a question per se, but I would say, first of all, thank you all for coming to testify because I think it lends a little bit more clarity into what the deficiencies are in the system.

I encourage you to please submit your testimony because we can follow up with further questions to DSS. And thank you. Thank you for being here.

MR. MERJIAN: Just one final point, please. In the budget that's going forward, please ensure that the budget for HASA includes sufficient funding to meet the 34 to one and 25-to-1. Without that, they'll never meet it. We've got to make sure it's there.

That's not something that's a request. It's legally required both by local law 49 of 1997 and the Henrietta D. lawsuit.

CHAIRPERSON AYALA: Yeah.

MR. MERJIAN: So, if you want to do something, please make sure that it's sufficient funding because a fully funded and staffed HASA will go a long way to getting folks desperately needed subsistence.

CHAIRPERSON AYALA: Absolutely. We've seen this in a lot of agencies, unfortunately, in the last couple of years. Thank you so much.

Okay, we will now be moving on to our Zoom panel. Alex Clavering.

MR. CLAVERLING: Good morning. My name is Alex Clavering. I'm a staff attorney with the LGBTQ Plus Advocacy Project at Legal Services NYC in the Bronx.

I provide legal representation to low-income LGBTQ Plus New Yorkers, many of whom are living with

HIV and struggling to access the services they need to survive. Annually, our dedicated advocates help over 100,000 low-income NYC residents.

People living with HIV need access to HASA's life-sustaining and saving benefits. Our current local law, specifically New York City Administrative Code Section 21-126 is a vestige of outdated language and notions. Ensuring eligibility to all individuals with HIV is not just the right thing to do, it is a necessary public health measure that will prevent suffering and save lives. This issue is especially urgent in light of the rising wave of discrimination against LGBTQ Plus individuals and people living with HIV.

In this climate, this bill would lay the groundwork for ensuring that every person living with HIV has access to the services they need without unnecessary restrictions or stigma.

While expanding eligibility as the amendment to New York City Administrative Code Section 21-126 does is a critical step, it is not enough on its own. HASA, particularly in the Bronx, all too often has been failing the people it is supposed to serve.

My colleagues and I regularly work with clients who have waited months, sometimes over a year, for services that should have been provided in days. Clients are denied emergency housing when they are clearly eligible. They are met with bureaucratic roadblocks that delay or prevent access to food and transportation assistance.

We have been working with Mr. Crane since fall of 2024 to obtain an emergency grant for rental arrears and to prevent eviction. Despite repeated advocacy, HASA has failed him at every step. Mr. Crane fell into arrears through no fault of his own.

This client's landlord refused to provide him with lease renewals, so rental increases were not budgeted into his HASA benefits. We were able to reopen the client's HASA case, which had been erroneously closed, and correct the ongoing shelter benefits. Nevertheless, HASA still refused to approve an emergency grant that would satisfy the rental arrears accrued.

Our client is especially vulnerable. He identifies as trans, is chronically ill, and has a history of homelessness. We have provided HASA with medical records showing that the client has been

hospitalized well over 20 times since the eviction case was filed.

He is also acutely immunocompromised, having suffered multiple cases of COVID, pneumonia, and other infections.

On top of this, he is dealing with clinical depression and anxiety and is extremely afraid of having to enter the shelter system, both as a chronically and acutely ill individual and as a trans man. We reapplied and submitted several requests for reconsideration of the emergency grant, which have all been denied to this date.

There has been no attempt on the part of HASA to have a social worker reach out to personally assist with this client with the emergency grant, or to explain these denials to him. Despite multiple requests, HASA has yet to provide written denials, ignoring its own assurances. HASA claims it denied the grantee to, quote "lack of proof" that he paid rent in the past three months.

We explained that our client was hospitalized and unable physically to go cash his social security checks to pay his share.

[BELL RINGS]

SERGEANT AT ARMS: Your time has expired, thank you.

CHAIRPERSON AYALA: Go ahead, you can wrap it up.

MR. CLAVERLING: Upon being discharged from a month-long hospital stay, he escrowed his share of the rent with our office in December of 2024. HASA has ceased communication with our office, ignoring multiple update requests, even as he faces a new eviction notice.

The amendment represents a necessary step toward a more just and humane system, one that recognizes that no one should have to wait until they are gravely ill to get help.

It acknowledges that housing and healthcare are intertwined, and that access to services should be based on medical facts and not arbitrary legal distinctions. It also asserts that in this moment of growing hostility towards LGBTQ plus and HIV positive individuals, New York City must lead the way in protecting and supporting its most vulnerable residents. Our clients would benefit greatly from the passage of this bill, and are in need of meaningful reforms to ensure that HASA delivers on its promise.

Thank you for your time and consideration.

CHAIRPERSON AYALA: Thank you. We will now be calling on Sarah Telson.

MS. TELSON: Good morning, my name is Sarah Telson. My pronouns are she and they, and I'm the Director of the LGBTQ HIV Advocacy Unit at Brooklyn Legal Services. Each year, our team of seven serves hundreds of people living with HIV and AIDS in their legal matters.

As you know, our clients rely on HASA for critical needs, including housing and other health-impacting needs. HASA plays a vital role in the lives of our clients. However, it is clear that there are gaps in service delivery that must be addressed to ensure that HASA is truly meeting the needs of our most vulnerable community members.

One significant issue that our clients report is that their HASA caseworkers are unresponsive. Clients report that they do not know who the caseworker is, or that they frequently change. Often, our clients have to retell their stories, resubmit documents, and repeat steps when they are already burdened by whatever legal issue that has brought them to our office.

Despite an expectation that applications be decided in 30 days, clients wait much longer, often several months. However, HASA's internal dating conventions don't reflect the actual amount of time an application has taken. As advocates, we experience the same difficulty in reaching caseworkers.

For each of our cases, a significant amount of time is spent just trying to reach someone at HASA and get an action taken. These delays have dire consequences. When HASA fails to respond, we are unable to resolve eviction cases, and our clients become perilously close to losing their homes.

Emergency requests are meant to be addressed within a specific timeline, and yet our experience is that these timelines are rarely, if ever, met. In Brooklyn, public benefits recipients who are not receiving HASA benefits have the ability to go to an office in Housing Court and seek rental assistance the same day they're in Housing Court. HASA recipients don't have that option.

With no access to an in-court process or equivalent, clients receiving HASA benefits face unnecessarily delays in their cases, and because we

do not and will not disclose our client's status and cannot, we cannot explain to the court why these delays happen, and the court doesn't have patience to understand why.

Another gap in services we have witnessed is a lack of oversight of supportive housing providers. Supportive housing residents are particularly vulnerable and rely on their providers for housing and services.

Housing providers are not following the required step procedures, further exacerbating our client's housing instability. Our clients find themselves in eviction proceedings because supportive housing providers are not making rent payments and then not showing up to court, putting tenants at risk of eviction through no fault of their own. As noted earlier by Chair Ayala, the NNC allowance has not been raised in 40 years.

This particularly affects people who have long-term tenancies in affordable apartments and ultimately increases homelessness. Our clients, especially those who receive Social Security benefits and are impacted by COLA increases would benefit from an increased allowance. Unfortunately, the current

amounts directly lead to a loss of affordable low-rent apartments.

As a city council, you have the power to hold HASA accountable for the quality of services it provides. We urge the council to immediately take action to ensure that HASA adheres to its own policies and timelines. This includes increased staffing, improved communication and oversight mechanisms that hold HASA accountable to the people it serves.

Thank you for your time and attention and we look forward to working together to improve HASA services and protect the housing security of folks living with HIV in New York City.

Thank you.

CHAIRPERSON AYALA: Thank you.

Terri Wilder.

MS. WILDER: Sorry, I'm having a hard time finding my screen. All right. Thank you. Good morning, Chairs Aliah and Schulman and members of the council. My name is Terri Wilder, she, her, and I serve as the HIV and Aging Policy Advocate at SAGE, the nation's oldest and largest nonprofit dedicated to improving the lives of LGBTQ plus older people.

I appreciate the opportunity to share concerns from LGBTQ plus elders living with HIV, many of whom rely on HASA services for health, housing and stability.

First, HASA must improve communication to ensure continuity of care. When case managers leave, clients are often left in limbo for months without knowing who will take over their cases. A formal transition process must be established to prevent gaps in support.

Additionally, communication failures such as unanswered calls, unassigned phone extensions and long wait times are widespread. Our staff has waited over two hours on the intake service unit line just to pull up on an application. These delays must be addressed.

Second, HASA must offer multiple communication methods beyond email. Many older people lack access to or are uncomfortable with email. HASA should document a client's preferred method of communication, whether phone, mail or another option at intake.

Third, income adjustments from social security should not disqualify people from HASA services. A

minor cost of living increase should not put someone at risk of losing critical support.

Fourth, safe and affordable housing must be a priority. Clients report mold issues worsening their health, landlords ignoring concerns and caseworkers providing inadequate responses like suggesting an air purifier instead of a proper mold remediation for the situation handled by the landlord.

Additionally, landlords receiving HASA funds must be held accountable for providing heat as some tenants fear eviction for reporting unsafe conditions. Stronger oversight is needed.

And fifth, rising rents are pushing people out of stable housing. We've seen cases where clients rent increased by $700 in just two years after HASA starting with a new landlord. Mechanisms must be in place to prevent excessive rent hikes that threaten housing security.

Sixth, outreach to older people is inadequate. Many older people living with HIV do not know HASA exists. A proactive outreach strategy is necessary to connect eligible individuals to these critical services.

Seventh, the HASA application process is too complex. One client's medical provider completed the required forms but the paperwork stalled for months because there was no instructions on the form about where to send it. Clear guidance is essential.

HASA must be equipped to meet the needs of an aging HIV community. As people with HIV age, they require more time and support from caseworkers. HASA must ensure staffing--

[BELL RINGS]

SERGEANT AT ARMS: Your time has expired. Thank you.

MS. WILDER: I'm almost done.

CHAIRPERSON AYALA: You can wrap it up. Go ahead, wrap it up.

MS. WILDER: Thank you. Finally, while we support updating the language in ADCODE 21-126, 21-127, and 21-128, we strongly recommend changing, quote, "every person with HIV infection" to, quote, "every person with HIV."

The term HIV infection is stigmatizing and organizations around the world, as well as the NIAID HIV Language Guide, have called for its removal.

In conclusion, HASA is a vital program, but improvements are necessary to ensure older people with HIV receive the housing, case management, and support they need to age with dignity.

Please note that more details around these issues can be found in our written submission. Thank you for your time.

CHAIRPERSON AYALA: Thank you. We will now be calling Jason Cianciotto.

MR. CIANCIOTTO: Good afternoon. Hi, everyone. I'm Jason Cianciotto. My pronouns are he, him. I'm the Vice President of Public Policy and External Affairs at GMHC. In 2024, GMHC served nearly 5,600 clients, many of whom received important support from HASA.

Thank you, Chair Ayala and Chair Schulman, for this important hearing, and to all the committee members for their longstanding support of New Yorkers living with HIV and AIDS.

I'm going to try not to repeat a lot of the really important and wonderful suggestions that have been shared already, so I want to start by expressing JMHC's wholehearted support for Chair Schulman's Bill T-2025-3096, codifying existing HASA practice into

law. That's a no-brainer, but important to ensure that what's happening now remains happening by putting it into statute.

One of the biggest challenges that our clients who receive HASA support are facing are the result of the intersection of social security cost of living adjustment increases and their HASA housing support.

I recently learned about a client who received notification that their HASA housing benefit on December 28th was going to end effective January 8th, all because the SSI COLA increase put them $16.26 above the current ceiling limit. Another had their housing support threatened because they were $11.86 over the income ceiling limit. Another $25.16. Another $1.00, another even 57 cents over the limit.

You can see where I'm going here.

So, JMHC has been in touch with OTADA, Senator Hoylman, who led S-183, for which Councilmember Ossé's Resolution 175-2024 supports, and the end result is agreement that the best way to address this issue for now is to increase the income ceiling from 200% to 250% of the federal poverty level.

Importantly, the HIV Housing for New York Plan advocated by the Ending the Epidemic Coalition, of

which GMHC is a member, includes that resolution, increasing to 250% of FPL. GMHC strongly supports all New Yorkers living with HIV, having access to the same type of housing support that those in New York City do. So, we certainly hope to see that in the state budget as that comes together, and we appreciate the Council's advocacy for that.

Before I run out of time, I wanted to share all of our deep concern over the threats the federal government has made to New Yorkers living with HIV and AIDS. I want to thank the Council for creating the Protect NYC Families Initiative in support of immigrants living with HIV who are served by many organizations, including GMHC's legal department.

[BELL RINGS]

SERGEANT AT ARMS: Time has expired, thank you.

MR. CIANCIOTTO: I'm done, thank you so much.

CHAIRPERSON AYALA: Thank you. Okay, we will now resume our in-person panel. Joe Hofs?

MR. HOFS: Good afternoon, Honorable City Councilmembers. I'm Joe Hofs. Thank you for allowing me to appear in person today. And I join my colleagues in echoing their urging the Council Committee for the resources to fund HASA. And from

the perspective of my firm, we believe that the folks that are served by HASA should be expanded to include folks with autoimmune diseases that are other than HIV. Long COVID, for example, or chronic fatigue syndrome are chronically plaguing our community and will, I believe, more in the future.

So, I think we need to get ahead of this issue and not only give HASA what they deserve, but think about expanding what HASA does.

I wanted to-- Should I continue?

Okay, another reason I wanted to appear in person today was to bring to the attention of the committee my belief that the CityFHEPS program being run by DSS is discriminatory to disabled veterans. And it sounds so brash, but there's no way to put icing on that.

I believe folks that are disabled veterans and assigned higher evaluative ratings from the VA are being told they're not eligible to apply for rental assistance through CityFHEPS. And I believe that because it's the case. From services for the underserved and home base, in DSS, they're simply being precluded from being eligible.

They're considering veterans' VA disability compensation, which is just that, compensation, as part of gross income, which is legally incorrect and needs to be rectified with all due respect.

So, I urge the Council Committee to direct DSS to work with us to rectify the situation. Thank you so much for listening.

CHAIRPERSON AYALA: Thank you, thank you so much. We have now heard from everyone who has signed up to testify. If we have inadvertently missed anyone who would like to testify in person, please visit the sergeant's table and complete an appearance card now.

If we inadvertently missed anyone who would like to testify virtually, please use the hand raise function in Zoom, and I will call on you in the order of hands raised.

Okay, seeing no one else, I would like to note that written testimony, which will be reviewed in full by committee staff, may be submitted to the record up to 72 hours after the close of this hearing by emailing it to testimony@council.nyc.gov. And with that, this hearing is concluded.

[GAVEL]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date February 15, 2024