CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON GENERAL WELFARE

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HELD AT: COUNCIL CHAMBERS – CITY HALL

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CHAIRPERSON

COUNCIL MEMBERS:

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CARLOS MENCHACA
ANNABEL PALMA
DONOVAN RICHARDS

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

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HRA-HASA

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CHAIRMAN, HIV ADVISORY COMMITTEE AT CARE FOR THE HOMELESS

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TRANS JUSTICE

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

CLARENCE HENDERSON
BOOM HEALTH

Good morning everybody. I am Council Member Stephen Levin, Chair of the Council's Committee on General Welfare. Today we are going to be hearing 2 bills related to the HIV/AIDS service administration, otherwise known as HASA. Int. No. 684 and Int. No. 935. I would like to thank the administration for… for being here today, advocates and HASA clients who have come to testify. I would like to recognize my colleagues; Council Member Corey Johnson of Manhattan, Council Member Donovan Richards of Queens and Council Member Annabel Palma of the Bronx and welcome back to Council Member Palma.

Int. No. 684 a local law to amend the administrative code of the City of New York in relations to provision of services of people living with HIV and AIDS is known as "HASA for all". This legislation sponsored by Council Member Johnson along with myself and Council Members Palma, Dromm and Menchaca, Mendez, Torres and Van Bramer would expand the services provided by HASA to individuals with HIV infection. Currently only those individuals with symptomatic HIV/AIDS may qualify for HASA services. This legislation would remove that requirement and allow any income eligible persons with HIV to access

HASA's critical services and I will ask my colleague Council Member Johnson to speak further on this legislation. Advocates have been consistently calling for the implementation of HASA for all and at a hearing this past June we heard testimony from many about the need for this legislation. At that hearing the Committee also heard from advocates about the needs for some procedural improvements to HASA programs including the increase need for information and transparency at the agency and the need for more consistent meetings of the HASA advisory board. In response to those suggestions, I've introduced along with Council Member Johnson a bill that seeks to update some of HASA procedural requirements.

Int. No. 935 would require the HRA commissioner to consult with the HASA advisory board before updating both HASA policy and procedures manual and it's client bill of rights. Which are both required to be updated annually. To address the lack of consistent meeting of the board this bill would also empower the Chairperson or 5 members of the advisory board to call a meeting and would require the board to produce annual reports. The bill would additionally increase the transparency of

HASA work by requiring the existing quarterly reports, the bill of rights and annual reports of the advisory board to be posted on HRA's website for all the public to see.

HASA provides a central services to low income New Yorkers living with symptomatic HIV and AIDS. Those services should be expanded to all income eligible New Yorkers with HIV infections so that no one have to choose between remaining homeless and forgoing a central medical treatment. There has been ongoing progress in the city and state around services for people living with HIV and AIDS including the implementation of 30% rent cap and want to commend HRA and this administration for that and the Governors and the epidemic recommendations. We hope to continue the trend with this legislation that we are hearing today.

The Committee looks forward to hearing from the administration regarding their stance on the legislation and from the advocates and clients regarding any suggestion for potential ways to improve the bill. I would like to thank our Committee staff for their work to prepare for today's hearing, Council Andrea Vasquez (sic), Policy Analyst

Tonya Cyrus, and Finance Analyst Dohime Sompora (sic). I'd like to ask my colleague, Council Member Corey Johnson to give some additional opening remarks.

COUNCIL MEMBER JOHNSON: Thank you Chair Levin, good morning. Thank you for holding this hearing to build on the conversation this committee began in June and your commitment to HASA. I also want to thank Council Member Palma who was the initial sponsor of the HASA for all bill and was caring this bill 8 years ago when this campaign began. She was a key person in this struggle so I really want to recognize her and thank her for her leadership.

We are here because we care deeply about HASA and it's mission. We believe that HASA needs to be strong, well-funded and responsive to the people it services. And expanded to serve even more New Yorkers who desperately need it. For many New Yorkers, HASA is the difference between life and death. For those with a AIDS diagnoses or a symptomatic HIV infections, it provides crucial case management and assistant with housing, food, transportation and access to healthcare.

Unfortunately eligibility for the program is currently tied under New York City local law to a New York State AIDS institute definition of HIV related illness. A definition that has not changed since the mid 1990's and is now out of date and is no longer used by the AIDS institute for any purpose.

HASA regulation require those who receive benefits to have an AIDS diagnoses or a symptomatic HIV infection, meaning a t-cell count of 200 or less or 2 optimistic infections. This is outdated and it needs to change. I am grateful for the great steps that the City and State have taken very recently to actualize this commitment in ensuring that all low income HIV positive New Yorkers could have access to critical housing, nutritional, transportation and other important services. A single plan of access for all low income individuals living with HIV and AIDS in every county was a key tenant of Governor Cuomo (sic) blueprint to end AIDS modeled off of success of HASA and this City must continue to lead by expanding it rolls. In New York City 1,000's upon 1,000's of people living with HIV including currently 800 or more who resided in New York City shelters. Every single night remain medically ineligible for

publicly funded HIV specific non-sheltered housing assistance, case management and transportation allowance that are provided for persons with symptomatic HIV infection through HASA. Homeless people with A-symptomatic HIV infection are often forced into the hopstince choice of initiating treatment and remaining homeless or delaying treatment until they qualify for rental assistance or supportive housing. The bottom line is this, housing is healthcare. When HIV positive people have adequate housing we see that they end up with increased rates of viral suppression and reduced mortality in their communities see lower HIV infection rates. On the other side of that coin, we have seen that homelessness has a direct and staggering impact on people's health. A large body of research demonstrates that homelessness and unstable housing are strongly associated with greater HIV risk and inadequate HIV healthcare, poor health outcomes and early deaths. A 2005 New York City study found the rate of new HIV diagnosis among homeless persons is 16 times the rate for general population. And death rate due to HIV and AIDS, 5 to 7 times higher among homeless people with HIV and

AIDS. For people living with HIV, lack of stable housing poses barriers to engagement and care and treatment success at each point in the HIV care continuum. With homelessness being one of the primary drivers of the spread of HIV and the progression of the virus into AID if passed this legislation will have a direct impact on the dual crisis of HIV and AIDS in homelessness particularly among LGBT youth of color. HASA for all is the compassionate course of action, but it really is the most cost effective course as well. Expanding HASA will not only save lives, it will also save money in the long run. Keeping people housed and connected to healthcare will generate significate savings in public spending for emergency room visits and avoidable healthcare services. Savings that more than offset the investment in these benefits. The same can be said for the nutritional services that HASA provides which allow for caloric intake that a person needs to take certain medications and stay healthy. HASA has involved in the 30 years since its creation. I want to thank one of my predecessors on the Council, former State Senator and Council Member Tom Dwayne (sic) for being the man that lead the

charge to create HASA and has always been a vital safety net for at risk populations but has not always been the most welcoming of invariance. During June's hearing many advocates testified about reforms that can help open the agency to clients an ease enrollment and access services for many more. It is fitting that reforms help navigate the case manager process will also be heard today. I'd like to thank all the advocates who are here today fighting for our most vulnerable New Yorkers. I also want to commend the current leadership at HRA, Commissioner Banks and Dan Teeths (sic) who are here today, who have embraced these goals and have been amazing to work with. Last year they announced an agreement on the 30% rent cap and hopefully this year we together can ensure that 1,000's of more New Yorkers receive these critical services. I want to say that as a the openly HIV positive member of this body and I believe the only HIV positive elected official in the State of New York, I am incredibly fortunate to have a steady income, good health insurance, access to a metro card on a monthly basis, the ability to each healthy food and it's what every person with HIV and AIDS deserves in New York City. I take this

responsibility seriously and advocating for others who may not have the same access to the benefits that I have.

And lastly, I want to thank Chair Levin for taking this issue very seriously for working with me on getting this hearing set up today. I want to thank the General Welfare Committee staff, particularly Andrea Vasquez (sic) who spent an enormous amount of time in drafting this legislation and to my legislative director, Louis Sholden Brown who started working on this the very first day that I took office. Thank you Chair Levin.

CHAIR LEVIN: Thank you very much Council Member Johnson we've also been joined by Council Member Carlos Menchaca of Brooklyn. And with that I will ask from HRA Dan Tietz, Chief Special Services Officer and Jacqueline Dudley, Deputy Commissioner for HASA to begin their testimony but before that I need to ask you to raise your hand please. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to council members questions?

{unisom Yes}

CHAIR LEVIN: Thank you, you many begin.

DANIEL TIETZ: Good morning, thank you Chairman Levin and members of the General Welfare Committee for giving us the opportunity to testify today.

DANIEL TIETZ: I'm Daniel Tietz, I'm the Chief Special Services Officer for HRA. Joining me today is Jacqueline Dudley, Deputy Commissioner for the HIV/AIDS Services Administration. Thank you for this opportunity. I just want to say to Council Member Johnson, it was very nice of you to mention Tom Dwayne. You're doing a great job following Tom Dwayne in this roll. I think it a very sweet.

We are here to discuss the provisions, the provision of benefits and services for New York City residents with HIV and more specifically to testify in regards to Int. No. 684, also known as HASA for All. This introduction would allow the City to expand existing HASA benefits eligibility to New Yorkers with HIV, but do not have AIDS or clinically symptomatic HIV consistent with current HASA eligibility requirements. We also address Int. No. 935 relating to the HIV/AIDS Services Administration

Advisory Board, data reporting, public comment and other non-substantive technical amendments.

HASA is arguably the world's largest and most comprehensive government program serving people with HIV and AIDS, HASA provides services and support to one of New York City's most vulnerable communities, namely those with clinically symptomatic HIV illness or AIDS. But we know that there are additional low-income New Yorkers with HIV who are not clinically symptomatic consistent with current eligibility requirements, but who would benefit from HASA services.

Much has changed since the early 1980s when a then unknown epidemic was rapidly spreading across the City, State and nation. At the 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 respond and proudly provided a range of critical services to those affected by HIV and Aids. HRA's crisis workers were proving emergency benefits and support services, as well as burial assistance, when many service organizations were reluctant to engage people with HIV.

Today's epidemic is very different from that of the 1980s or even the 1990s. What we have learned since then is when people are provided treatment, comprehensive benefits and case management they are able to experience a higher quality of life and live near-to-normal lifespans.

But much remains to be done and we are working with key stakeholders to end New York State's epidemic, which is mostly concentrated in New York City. Indeed, almost 80% of New Yorkers diagnosed with HIV in the State live in the 5 Boroughs.

As this Committee is well aware, there is no cure for HIV and it remains a disease marked by poverty and continued stigma and discrimination. As such, HASA services are essential to ensuring that low-income New Yorkers with HIV obtain the benefits and services they need to remain healthy and live independent lives.

Although HASA presently serves only those with clinical or symptomatic HIV and Aids, and their families, we are also focused on preventing new HIV infections. HIV transmission does not occur in isolation and although anyone of any age, race, religion, sex, gender or sexual orientation can be at

risk, those at greatest risk include: individuals without access to culturally competent care, free condoms, clean syringes and new prevention tools, such as pre-exposure prophylaxis or non-occupational post-exposure prophylaxis. Individuals without medical insurance and related healthcare supports. Those who lack access to HIV and STI testing and screening and who experience delays or barriers in moving from a positive HIV test to linkage and engagement in treatment. Individuals with a history of incarceration. Those with status undocumented migrants. Men who have sex with men, particularly young black and Hispanic or Latino MSM. Transgender individuals, especially transgender women. Women of color. Those who use injection drugs, but don't have access to clean syringes and sero-discordant couples.

Likewise, mitigating poverty, preventing homelessness and ensuring stable and affordable housing, addressing food insecurity, unemployment and underemployment, and ensuring access to treatment for substance use disorders and mental health care are vital to both averting new HIV cases and ensuring consistent engagement in care and services for all low income New Yorker with HIV.

In May 2015, Governor Cuomo released the Ending the Epidemic Task Force's 'Blueprint', which is a consensus document the content of which was agreed by all Task Force members, including me a other participating City officials. The Administration fully supports the Blueprint's goals and concepts and we are working closely with our State partners to ensure the plan is implemented.

The task force went beyond it's initial charge and included additional recommendations to ensure universal access to HIV prevention, treatment, care and support. There so-called "getting to Zero" recommendations address key social, legislative and structural barriers and envision a place where there are zero new infections, zero AIDS deaths and where HIV discrimination is a thing of the past. In the getting to zero recommendations, the first such recommendation is most directly relevant to HRA and Int. No. 684, under consideration today.

GTZ recommendation 1: Single point of entry within all local Social Services Districts across New York State to essential benefits and services for low-income person with HIV and AIDS.

This recommendation seeks to create in other Social Service Districts a version of HASA, which is the single point of entry in New York City for such benefits and services for person with clinical or symptomatic HIV or AIDS. Under GTZ recommendation 1, HASA would expand to all low-income New Yorkers with HIV, and not only those with clinical or symptomatic HIV and AIDS who are presently eligible. As with the other Blueprint recommendations we are committed to working closely with our New York State partners, as well as advocates, providers and people with HIV to determine how best to act on this recommendation.

Int. No. 684 tracking GTZ recommendation 1 from the Governor's Blueprint, Int. No. 684 would require HRA to expand, pardon me, would require HRA expand HASA eligibility to include person with HIV who may otherwise not qualify simply for not being sick enough.

As previously mentioned, every day the comprehensive services provided by HASA are helping New Yorkers with clinically symptomatic HIV and Aids to live a better quality of life and to live near-to normal lifespans. Further, by ensuring that clients

are not choosing between healthcare and housing or food we are improving public health and decreasing transmission rates through continued attachment to the continuum of care. We agree with the Council that extending HASA benefits would have a similar positive outcome for low-income New Yorkers with asymptomatic HIV, and their families and we therefore support the goals and concepts outlined in Int. No. 684.

The costs associated with Int. No. 684 would require significant resources from both the City and State in order to expand HASA to all low-income New Yorkers with HIV. We will continue to work with our New York State partners to seek sufficient funding to expand HASA services to all New Yorkers with HIV. Likewise, we look forward to working with members of this committee and the entire City Council as the budget process begins in Albany to ensure adequate State funding to allow us to extend these lifesaving benefits to every eligible New Yorker in need of such support. Given the consideration of these matters in upcoming, in the upcoming State budget process, we appreciate the

provision in Int. No. 684 that links implementation to action by the State to provide sufficient funding.

Int. No. 935 relates to the expanded function of the HASA Advisory Board, data reporting and other non-substantive technical amendments. We are proud of our new reforms and initiatives at HRA and although it's very early, we believe our reform measures will achieve great success. As such, we want our policies and data to be clearly understood and available on HRA's website. It is a goal that is consistent with the Mayor's focus on a accessible government.

To this end, shortly after Commissioner Banks was appointed, HRA created several workgroups that include a mix of providers, advocates and HRA leadership to discuss service challenges, barriers and policy issues, as well as potential solutions. Among these workgroups in the HASA workgroup, which has met several times since last summer. That would be summer of 2014. This workgroup facilitates advocates and providers brining HASA related policy and practice concerns directly to the program and HRA's leadership to that we can collaboratively develop sensible solutions. It is an effective

approach to understanding and responding to the community's needs and making policy and service improvements in HASA. The workgroup presently meets quarterly and will be meeting again tomorrow.

HASA also maintains an Advisory Board in accordance with Local Law 49 of 1997. The Advisory Board consists of 11 individuals with five members appointed by the Council and 6 appointed by the Mayor, including the chairperson. At least 6 of the appointees are required to be eligible for HASA services. The board meets quarterly to advise the Commissioner on access and the provision of benefits and services to person with clinical, symptomatic HIV and AIDS.

In short, HASA's senior team routinely meets with advocates, academic, elected officials, key stakeholders and clients to ensure that we are providing high quality comprehensive services and we take their recommendations and proposals for improving service delivery, policies and procedures very seriously.

Allowing the Advisory Board additional opportunities to meet and develop robust recommendations to the commissioner is a concept that

we support. However, the bill creates some ambiguity as to whether the Board must meet quarterly and as additional times upon the request of 5 members, or whether the request of such members serves as an alternative to the board's chairperson convening the already required quarterly meeting. We suggest revising the language to provided that a simply majority may override the chair person in the event that the chair declines to call a meeting. We welcome working with you on modified language to accomplish the goal of the legislation without inadvertently impeding the ability of the Advisory Board to work collaboratively.

As previously mentioned, we agree that data reporting, revision to the HASA Bill of Rights and revisions to policies and procedures should be transparent, available on HRA's website and subject to public comment. We suggest, however, that the proposed requirements regarding prior public review of policy changes be modified so as not to slow reform efforts. Under CAPA, we are already required to hold hearing when considering changes to policies that affect a client's rights and procedures. But as presently drafted, this bill would require more by

mandating hearings that will likely serve little purpose. For example, had the proposed provision been in place last year, it would have limited our ability to expeditiously implement the 30% rent cap as required by state law. We stand ready to work with the Council on modifications to accomplish our mutual transparency.

At these hearing we also like to take the opportunity to discuss agency reforms. As with all program areas at HRA, during the past 21 months we have been determining and implementing reforms and new initiatives within HASA to better service our clients and ensure the best use of our staff and resources.

As mentioned above, we instituted a HASA workgroup, which presently meets quarterly and includes a mix of providers, advocates and HRA leadership to discuss services challenges, barriers and policy issues, as well as potential solutions. Arguably of particular relevance to HASA, we also have a LGBTQI working group that meets quarterly and is meeting as we speak. But we've also instituted additional reforms and below are several of these as they relate to HASA and our clients. We've

implemented a new cultural competency training developed by our Office of LGBTQI affairs. Approximately 1,200 employees have been trained to date, including 269 in HASA, I should note HASA has about 1200 staff, 825 in FIA and 105 in MICSA, which is the Medicaid division at HRA. With a goal of training HRA employees in the coming year. We expeditiously implemented to the 30% rent cap, which was first approved in the Sate's FY 2014-15 budget. We are now providing HASA clients with access to vocational services and supports to better prepare them for the workplace. We are consolidating securing and managing HASA emergency housing under a single master contractor to more efficiently manage this housing and the payments to multiple providers. We are working with key stakeholders to act on the Governor's blueprint recommendations, including expansion of HASA to all low income New Yorkers with HIV and not only those with clinical or symptomatic HIV and AIDS who are presently eligible. We are continuing to consult with the HASA advisory board in effort to improve HASA services.

I would like to close with an interview, with an overview summary of HASA services. For

further detail concerning the program and series within HASA, I refer this Committee to my June 24, 2015 testimony which can be found on the HRA website.

HASA services include assistance in applying for public benefits and services, such as: Medicaid, Supplemental Nutrition Assistance Program benefits, cash assistance, emergency transitional housing, non-emergency housing, rental assistance, homecare and homemaking services, mental health and substance using screening and treatment referrals, employment and vocational services, transportation assistance and SSI and SSD applications and appeals.

HASA clients are assigned a caseworker at one of our HASA centers, which are located in all five Boroughs. Caseworkers work face to face with clients on applying for cash assistance, Medicaid and SNAP and if eligible for HASA, can receive same day assistance. Caseworkers assist clients by identifying their needs and creating individualized services plans to secure the necessary benefits and supports specific to addressing their needs and enhancing their well-being, taking into account the complexities of their illness. In addition to securing the public benefits noted above, HASA

caseworkers also refer and link clients to community based organizations and providers for a host of health, mental health, substance use and housing resources.

Taken together, this investment in HASA's target benefits and services recognizes that peeving disease progression and relieving poverty saves lives, averts costs and advances health and wellness to only for individual clients, but also by helping to limit the further transmission of HIV.

HASA is mandated to provide timely delivery of benefits and services, as well as emergency housing, to all homeless HASA clients. Let me provide a brief snapshot of our current clients.

As of October 6, 2015, HASA provides services to 42,809 individuals, which includes 32,072 clients and 10,737 associated case members.

A few data points regarding HASA's current clients as of July 2015. The median age is 50 with 50% age 50 or older. A third are female. More than 95% receive Medicaid and SNAP benefits. 24.1% receive federal SSI benefits and another 8.9% receive SSD benefits. 4.9% receive both SSI and SSD. 84.7% receive cash assistance, including some who are also

receiving SSI or SSD and for whom CA helps to cover housing cost and 4.4% of clients have earned income.

Now I'd like to focus on a few key services, including housing assistance, medical assistance and financial assistance.

As of September 19, 2015, HASA's contracted supportive housing portfolio consists of 5,678 units of which 5,420 are occupied. HASA spends $134 million annually for these units. There are 2,672 scattered-site units available, including NY, NY III and non-NY,NY III of which 95% are occupied. The average annual cost per unit is $23,957. HASA has 2,181 permanent congregate units, including both NY,NY III and non-NY,NY III, of which 96% are occupied. The average annual cost per unit is $22,200. Of HASA's 825 transitional units, 96% are occupied. The average annual cost per unit is $25,160.

In addition to supportive housing units, HASA is expecting to spend about $33 million this year for clients residing in emergency housing. As of October 3, 2015 of the 2,224 units available, HASA clients occupied 1,923 units, an occupancy rate of 86%.

The vast majority of HASA clients, over 19,000, live in private market apartment, with most receiving rental assistance subsidies to allow them to live independently.

Financial assistance, currently, there are 26,786 HASA clients receiving cash assistance, which also include transportation and emergency grants and 30,022 HASA clients receiving SNAP benefits. Thank you again for this opportunity to testify. I'm happy to answer any questions.

CHAIR LEVIN: Thank you very much Mr. Tietz, I will turn it over to my colleague actually first for the questions. First can I have Corey Johnson.

COUNCIL MEMBER JOHNSON: Thank you Chair Levin. Thank you Dan for the very comprehensive helpful testimony and you know I should have said this in my opening statement but anytime I have had a constitute or any New Yorker that has an issue or problem navigating our sometimes complicated bureaucracy I have gone to you and you've have been incredibly helpful and thoughtful and I really appreciate our ability to work well together. I think some of the statistics that you rattled off

are, I don't think shocking is the right word but I don't know if people would necessarily understand that the median age for these benefits is 50 years old. And I think some people would that's a surprise to a lot of folks and when you go through and you talk about nearly 85% of… of folks that are enrolled in HASA receive cash assistance, many folks 95% receive Medicaid or SNAP benefits. We're talking about New Yorkers that are poor. That are defiantly poor and so now what's not in here is what is the income eligibility guidelines for HASA, typically what is the average person, what's their average income if their enrolled in HASA?

DANIEL TIETZ: Well the vast majority gets public assistance so it's attached to the public assistance level. There are a smaller number as you heard have earned income you can earn a (inaudible) income. There are under state law you can, you can ignore have of their income for a period of time, if it's earned income. So it's quite low, so it's actually at the public assistant level.

COUNCIL MEMBER JOHSNON: And what is that. Do you know what that number is?

DANIEL TIETZ: You know it's complicated as you mentioned, so it turns you know in HASA of course it turns on an equation budgeting you don't have don't have David Sonta (sic) here today who could do this way better then I can. But it turns on an equation that includes your rent, so your assistance the, your eligibility is a mix of both your income and you cost.

COUNCIL MEMBER JOHNSON: Ok. So

DANIEL TIETZ: It's quite low, I mean there's no doubting that (inaudible).

COUNCIL MEMBER JOHNSON: So I really appreciate that you said that the administration supports the goals of my legislation of the Int. No. 684 and you and I have the opportunity over these past many months to work together in trying to understand what that would mean for the City of New York. I know that today you're not in the position to be able to talk about the exact cost associated with being able to implement HASA for all. One key question I have though is how would this affect case management for HASA which is a part of the initial law.

DANIEL TIETZ: Well obviously you would have to add staff without a doubt you know if you add numbers were adding Staff. Under current law there those ratios are set. High and local Law 49, this administration has staffed up in the time we been in office to… to meet those requirements so we would adhere to those as long as they're there.

COUNCIL MEMBER JOHNSON: Do you have any since of how… how many additional staff you would have to hire, a range?

DANIEL TIETZ: I don't.

COUNCIL MEMBER JOHNSON: Ok.

DANIEL TIETZ: I mean I can certainly get you a number, you know we've have looked at with our colleagues at DOHMH to try and figure out what the numbers would be. It's just in terms of the to the course it turns on. If the case worker and… and the supervisor ratio turn on client numbers in local Law 49, so working with DOHMH on the likely number, we become eligible then we back into the staff members.

COUNCIL MEMBER JOHNSON: And approximately do you have a since of how many individuals are currently living in the near, I know

you're not from DHS but how many people currently living in the shelter system are infected with HIV?

DANIEL TIETZ: So I know that DOHMH has a done a match which would get you part way there right. So at any one point in time DOHMH can do a, cause I understand a confidential match of course that would have some limitation because they're going to know from reporting those folks who tested positive you know in the five Boroughs. You're not going to know, so say somebody relocates to New York City they might not know that person so they've not gotten care or services in New York City, they may not know those folks. But I… I can get you a number, I don't, I want to say that it's in the several hundreds it's… it's not a giant number.

COUNCIL MEMBER JOHNSON: And do you have any since currently how many New Yorkers are denied HASA services because they currently do not meet the medical criteria?

DANIEL TIETZ: I don't believe that we track that number.

COUNCIL MEMBER JOHNSON: Ok.

DANIEL TIETZ: No.

COUNCIL MEMBER JOHNSON: Ok.

DANIEL TIETZ: So essentially you're saying if someone comes.

COUNCIL MEMBER JOHNSON: Someone comes.

DANIEL TIETZ: 108th avenue and wants services, I don't think we actually, I don't think we know the number that.

COUNCIL MEMBER JOHNSON: I think… I think it would be helpful to know that number. Just to give us a since of how many people potentially have the need but currently don't meet that medical.

DANIEL TIETZ: Yeah, let me see what we can do.

COUNCIL MEMBER JOHNSON: Ok. Do you have the current average moving expense for a HASA client, you know the cost related to when a HASA client needs to actually make a move and get into a new apartment.

JACQULINE DUDLEY: I would think that average moving is, I guess it will depend upon obviously the size of the apartment and would have to obviously get a truck, you're talking about moving or getting a new apartment as well?

COUNCIL MEMBER JOHNSON: Moving.

JACQULINE DUDLEY: Just moving what we do is we ask the client to get three estimates for

moving expenses and we take the lowest estimate from a licensed moving company and I think it normally ranges about $500. $500 to $600 just for the physical move.

COUNCIL MEMBER JOHNSON: Ok. Then in the housing assistance numbers that you rattled off, you said that HASA contracted supportive housing portfolio consist of 5,678 units of which all but 258 are unoccupied. The 258 that current, that currently are not occupied are people waiting are they on a list to get in?

DANIEL TIETZ: Oh no it's… it's that's almost holy turnover.

COUNCIL MEMBER JOHNSON: Oh it's almost open.

DANIEL TIETZ: Yeah it just, it's just some turn so there's you know our effort with all of our units is to keep them filled, some of that is just transition.

COUNCIL MEMBER JOHNSON: And I'd just to point out which I'm sure you know, we know but it's important to say that the scattered sight units average annual cost about $24,000 annually. The permanent concrete units $22,000 annually per person.

The transitional unit $25,000 annually, that is much less then we pay for someone to be in the shelter in New York City. And the other cost associated with medical concerns, so it's what I said in my opening which is, which is I think both the compassionate and the cost effective way to handle this special population.

DANIEL TIETZ: Absolutely.

COUNCIL MEMBER JOHNSON: I thank you Mr. Chair.

CHAIR LEVIN: Thank you Council Member Johnson. I have a few questions then I'll turn it over to my colleague Council Member Menchaca. I might be jumping all over the place a little bit but. How many more, how many more clients in HRA's destination would be brought into HASA if HASA for All were implemented?

DANIEL TIETZ: Were working with our colleagues at the DOHMH to estimate that number, I don't have a number that I can share today.

CHAIR LEVIN: Ok. Do you have a sense of in terms of the cost what the cost to be over all and how that could be, how that would be distributed between the City and the State?

DANIEL TIETZ: Well obviously you know that cost return on the number so we're working on that as well and you know we as I noted in the testimony you know we're working very closely with our partners in State (inaudible) DOH on how the cost would be covered. You know it's substantial portion of the cost is also you know on the DOHMH side and solely the HRA some of that of course Medicaid cost the whole host of cost in there, that were working with our (inaudible) to both figure out those numbers and determine how there split.

CHAIR LEVIN: We implemented with the state 30% rent cap, can you tell us on how that's spend going in terms of implementation, have there been any unexpected challenges that HRA has encountered?

DANIEL TIETZ: I think the roll out went exceedingly well. We… we very quickly moved to implement the rent cap such step by last July they were some 8,000, July 14, but there were some 8,000 New Yorkers in receipt of the rent cap and that City in fact covered the cost from the first of April 2014 that the State began to pay it share in July so we quickly implemented it. I'd say.

CHAIR LEVIN: City went retroactive from the date it implemented?

DANIEL TIETZ: Yes, that's right. I think you know if there's a challenge in there, it's that, I'd say there's two things; One of course is that the State share (inaudible). It's an appropriation at 9 million dollars annually at present. So it's not a new entitlement, presage, so work to be some number (inaudible) more clients you know the State share ends at 9 million. And that's the cost that split between City and State at 71% paid by the city, 29% paid by the state. And then fortunately we don't, I don't believe that we collect their 9 million dollars first. So… so it really is 71/29 split. I think the other challenge that we recognize is that as crafted in State law, some of the folks with in particular with higher SSD benefits may not qualify for the rent cap. They many have more then… then $376 left over at the end of the month when you do the budgeting in HASA and hence wouldn't then qualify for the rent cap because they have to be in receipt of public assistance at not nearly TAL's in receipt of public assistance and they couldn't be in receipt of public

assistance if they have more than $376 left over at the end of the month. So that's a problem.

CHAIR LEVIN: And how many, how many individuals?

DANIEL TIETZ: I knew you were going to ask that now, I was just about answer it. And our estimate is right around 800 folks that we know of who are… are in receipt of HASA benefits who look like they would be eligible for the rent cap. If would could do something about that budgeting issue. We're talking with our colleagues at OTDA, I don't think that we have a great fix yet, I think that just at the least would probably take State regulatory change but could even arguably take a State legislative change. So we're not done pressing on that.

CHAIR LEVIN: That would just insist to increase left over amount would take, may take legislation?

DANIEL TIETZ: I think it's from OTDA from the State's prospective that would produce a host of other challenges because of course if he were to do that for this population, if he were to just

adjust the public assistance number you'd have to adjust for all.

CHAIR LEVIN: Across the board.

DANIEL TIETZ: Right.

CHAIR LEVIN: Not just for HASA.

DANIEL TIETZ: So that I think they're some other potential approaches for this, I mean one but put that offering up you know all of our idea's here, I would just say that… that we certainly have reported to them how best to do this.

CHAIR LEVIN: So the percent, so the percentage then of HASA clients that are subject to a 30% rent cap would be the percentage of clients that are qualifying for or that receive public assistant which is 80, excuse me 84.7 % is that right or?

DANIEL TIETZ: It's about 8,600 who I receipted of the, of the rent cap now. Remember if you're on public assistant, so if your only income is public assistance then you have no need of the rent cap, cause we're already covering the cost of you're in your in a private market apartment, we're already covering the cost of your apartment. This is for folk who got income of some sort.

CHAIR LEVIN: I see.

DANIEL TIETZ: So SSI, SSD, earned income.

COUNCIL LEVIN: I see. So I want to ask a little bit about the rental assistance level. There are three levels; standard enhanced and above enhanced. Can you, can you explain a little bit about who's qualifying for standard, who qualifies for enhanced and who qualifies for above enhanced and the breakdown of how that goes?

DANIEL TIETZ: We're going to give that our best, when I said earlier that budgeting is complicated you know I'm we're actually I should know we're about to issue, you know we have a monthly fact sheet, it gets posed on the website. It's a little delayed because we got frustrated with our numbers. And so there's a revised one that about to be posted for July that actually breaks this out cause I think we were at previously see little apples and oranges on… on assistance type versus housing type and we sorted that better then we had previously so, it speaking of transparency is not far more transparent, but I'm going to let Jackie do the answer your question.

JACQUELINE: Ok, we're going to give it our best shot. I've indicated earlier it's really has a lot to do with your rent and your housing. For the most part but vast majority our clients receive retro assistance at the above enhanced level. No as you probably know under State regulations for a single person it's $215 for a single person, but there's also a regulation that for a person living with HIV related illness they can get an increase up to $480 but for our purposes the only clients who you normally get shelter allowance at that lower level, is people who are living perhaps sharing an apartment or perhaps living in a (inaudible) apartment or something like, some other subsidized housing program. For clients who are living in private market apartments where as you know that the rents are very high in the City of New York right now. Normally in order to keep them housed we're having to pay shelter allowance at far above the $480 which is mandated by the state. So therefore, those with clients who are getting, if we having to contribute to their more than $480 per month for a single client, then that's when we're, they're going to be above enhanced.

CHAIR LEVIN: That's above enhanced. So above $480 is above enhanced?

JACQULINE DUDLEY: Exactly.

CHAIR LEVIN: So because like I live in Greenpoint, I was listening to the radio the other day and somebody called in, he said I got an apartment, I live in Greenpoint now, apartment is 800 square feet. Which is you know big but it's not like huge.

JACQULINE DUDLEY: Right.

CHAIR LEVIN: And… and their' paying and they got a deal for $3000 a month. So in the neighborhood like Greenpoint which is not like generally considered a very expensive neighborhood. So then… so then is there a maximum rent level that above enhanced can hit because if a client you know is, I mean and that an indication of where rents are everywhere, there's nowhere, there's nowhere in New York City right now where your able to get like a one bedroom apartment for like $800 a month, I don't that really exist that much anymore. I mean I don't maybe it does but it's not a lot of them. And… and so like $480 if you got a 30% rent cap and or your receiving public assistance you know $480 is just not going to

cover it like anywhere. You know so is there a maximum, is like is there a you know if somebody wants to live in Greenpoint, Williamsburg or Bedsti or Fort Green, is there an ability for HASA to cover significantly higher like $1500, $1800, something like that.

DANIEL TIETZ: So we have guidelines and they generally tap out around $1100 a month for a single. But we also have in HASA a case by case financial analysis which essentially affords us the flexibility to go higher. The current median in HASA is around $1050 or $1100 and it's that low for a few reasons; one is that some folks have been in their apartments for a very long time and they come in at some low number and they potential a (inaudible) unit and they get whatever increase, there are some number who live in (inaudible)so the number you know ends up being that low for those, for those reasons. Obviously you know when someone is having to find an apartment today, you know it much much more difficult. There's you know, frankly there's also a good number of clients who have roommate's situations or have family who have unemployment so then the rent is split, you know the family member are making

contribution to the rent, we're paying you know whatever we're paying it could be a far smaller number $600 or $800 for their portion of the rent. So we actually have the flexibly to go higher and you know look at each individual circumstance. The numbers I mentioned by the way are for singles. I didn't you know they are obviously a different set of number for families, so two person, three person, four person.

CHAIR LEVIN: I'm going to turn it over to my colleague Carlos Menchaca for questions.

COUNCIL MEMBER MENCHACA: Thank you Chair and I want to just applaud for the leadership of both Chair Levin and Chair Johnson, just listening to them every time talk about it both here as a Chair but also in the halls of our City Council and progress cockas and any time we talk about this issue, it elevates it even further every time. So I just want to say thank you to Council Member Johnson, Chair Johnson and also extend a thank to the team. You and Erin and Commissioner Banks have just done an extraordinary job of working with us in the City Council to really push the mule forward. Not just in victories that we have already celebrated but in what

we're working on now and so in that theme I'd like to go further in Council Member or Chair Levin's questions about really understanding the cost of this and I hear that you're working on it, so tell us how you're working on and I want to understand the strategy of how you're going to come to this number in the first place of folks that are at the, at the understanding the number and understanding the cost. In so I understand that you don't have that number today, but can you tell us about how you're getting to that number. Give us the strategy about how and I mean I can only image how complicated this is but I think it's going to be important for us to understand how you're doing that.

DANIEL TIETZ: Sure, so you know obviously a chunk of this isn't really directly for HRA because you know we don't have the confidential registry of people with HIV in New York City that's held by DOHMH. And I'm not a status ion but I can give you some on how. So we can do some data match and figure out so who has HIV in New York City that are already known to us for some purpose or another. We also have DOH has data of with regards to deaths, so there's the in and out right so the fact that

someone would have been diagnosed here and reported 15 years ago doesn't necessarily mean that their still here. So this is some sorting of a list both DOH and DOHMH with regards to how many move-ins, how many move-outs, estimated regards to death or who haven't spent have a viral load which also needs to get reported, haven't had one of those done some lengthy period of time, then the presumption is they no longer live here or they died. So we've, there's, there are estimates or ranges that we're working on with DOHMH to try and figure out well how many, could be have HIV not AIDS, not currently eligible, not known to us who are still in New York City, could conceivably come for services, were the services open to them and what come for services were they open to them and then what service would they need. So what all would be expected to get to them. I think that there are some differences so we… we note that the median age for example is 50 that's not striking if you look at the epidemic across the Country, It's an aging epidemic. There's some good news in that right and that they made it to 50 in and above because their engaged in treatment but we expected that the newer crowd would be much younger, much healthier,

some significance number could be employed and then wouldn't necessarily be income eligible so we have to make some estimates in regards to poverty. So you see the complications both in terms of that.

COUNCIL MEMBER MENCHACA: And this is, I think this is really helpful and important this is a multi-agency requires multi-agencies corruption DOHMH who have a Department of Homeless Services as well and in so data from DHS so are these, are these already channels that are open and your… your…?

DANIEL TIETZ: Yes.

COUNCIL MEMBER MENCHACA: Yes.

DANIEL TIETZ: Yes.

DANIEL TIETZ: Ok good. Now and so this is all leading to the catapult capture of full New Yorkers and really underscoring the HASA for All component. What I want to understand now and this kind of next set of questions is where are immigrant community comes in, we are prepared to move this conversation forward on so many levels under HASA, under Healthcare, Chair Johnson and I are really, kind of really trying to understand and unpack how the immigrant community can… can get connected. Can you tell us the barriers that you're seeing right now

with our immigrant community both on the documented status and undocumented status for a program like this?

JACQULINE DUDLEY: I think one of the barriers I think, one of the good things about the HASA program is that we are able to provide access to certain benefits including cash assistance and Medicaid to people who are immigrants, who may be undocumented. We have our process by which if their able to just show evidence that they have made themselves known and contacted in anyway, US, CIS we can then make them eligible for Medicaid and cash assistance so that… that is.

COUNCIL MEMBER MENCHACA: So there's a few, there's a few elements of… of the overall HRA package of services for clients.

JACQULINE DUDLEY: Exactly.

COUNCIL MEMBER MENCHACA: But when we talk about HASA there is, I think there's a… a reality that HASA as a program, as an initiative is not open to our undocumented immigrants in New York City.

JACQULINE DUDLEY: I don't.

COUNCIL MEMBER MENCHACA: So I want you to tease that out for us a little bit.

JACQULINE DUDLEY: The HASA is not open to.

COUNCIL MEMBER MENCHACA: To our immigrant community, so our undocumented New Yorkers.

JACQULINE DUDLEY: Oh yes, there is no, you don't have to be a documented immigrant in order to receive HASA services, that is not the case. If you come.

COUNCI MEMBER MENCHACA: So tell us a little bit about that.

JACQULINE DUDLEY: If you were to come to service line and ask for admission to the HASA program, now keep in mind the HASA program itself just to be eligible for intensive case management and linkages to other CBOs Community Based Organizations who may be able to help you with things of that nature, there is no financial eligibilities requirements for that at all. Anyone who meets the medical requirements who come to us can be eligible for intensive case management. Now the tricky park obviously comes when that person also needs to apply for benefits and they're certain benefits that particularly like, SNAP that's purely federal, that's obviously problematic for a person who are

undocumented and then cases like that we try to assist them with linkages to other community programs that can assist them. But we certainly have language translation services available to them, we have posters in center and various languages that would notify a person entering into our center that if you need interpretation services and it's in I think at least 18 to 22 languages, those are printed on the posters notifying the person coming into the center that if you need translation services let somebody know, we can help with that. We have telephonic interrupter services for this that can assist. And we can again upon any notification upon proof that they have made themselves known to USCS they can be eligible for shelter allowance and Medicaid and the medial care obviously is what's really important. One of the things that's really important for a person coming into the HASA program.

COUNCIL MEMBER MENCHACA: Great and I guess I can just end there and know that we are very interested in this piece. As we get closer to the reality of HASA for All, I really want that to be not just a name but an actual experience for all New Yorkers and we're working on pieces where that don't

fit do to our federal or lack of leadership on the federal level but for the city in so we're breeding this concept of HASA for All and the complicated and unfair system but I think this is going to be an important thing as we continue to work with you, that to make it, to make it actually wat it say's which isn't HASA, it HASA for All, which is why I'm supporting this piece of legislation but also supporting you at the State level when we have to make some very kind of clear demands from our State. Wherever we can to change the percentages because there not fair right now of contributions to this program. So I'll end there and really kind of think about what that's how we can make that… make that helpful and it's not just about language we know that now, this is not just about having something in their language this is about cultural competency with our immigrant community as well. I am so hoping that… that we can, we can continue to push that forward.

CHAIR LEVIN: Thank you very much Council Member Menchaca. Council Member Johnson.

COUNCIL MEMBER JOHNSON: I just wanted to add I'm really grateful that Council Member Menchaca raised all these points related to immigrant access.

You know the Mayor unveiled last week an immigrant access plan for not health insurance but getting people into medical care and we have to ensure that why as Chair of the Immigration Committee, Council Member Menchaca and I have been working very closely together on ensuring that whenever we talk about the expansion of programs we're talking about how it relates to undocumented immigrant and documented immigrants and also when we talk about HASA for All we need to do the same thing. So I'm really grateful that you Dan talked about that specific population in your testimony and Chairman Menchaca (sic) and I are working very closely together whenever we're seeing an expansion of services on how to include everyone and ensure that everyone is covered by that. So I'm really grateful that he raised these really important points today.

CHAIR LEVIN: Thank you Council Member Johnson. Mr. Tietz and Deputy Commissioner I wanted to ask about the current status of with regards to other expanded rental subsidy programs that have taken affect over the last year or so. We've seen an increase in the link program and number of different interactions and other expanded rental subsidies that

HRA have undertaken whether it City FEPS (sic) and Expanded FEPS as well. I what are you seeing on the ground in terms of are you seeing landlords reluctant to take HASA because their holding out for links or anything like that? Is there anything that you're, that you're seeing or that you're hearing from providers you know if their seeing that.

DANIEL TIETZ: No, we explicitly mask the (inaudible) the broker payment so as long as for example LINK is paying the current you know 15% of an annual rent then we're doing the same at HASA, so it's not to disadvantage the HASA program with regards to apartment finding. I would say that the as you know in… in LINKS in City FEPS and in FEPS there at the section 8 rates. So there isn't flexibility with regards to the amount of the rent, so that's set.

CHAIR LEVIN: Set at.

DANIEL TIETZ: At the section 8 rate.

CHAIR LEVIN: Which is?

DANIEL TIETZ: Well it varies so.

CHAIL LEVIN: Maximum.

DANIEL TIETZ: I don't know the maximum, but the… the for a family of three I think it's $1550.

CHAIR LEVIN: Right.

DANIEL TIETZ: If I recall. Where as in HASA we have the case by case financial analyst and the freedom to do flexible. So you know I think the HASA program versus the LINK is well known to many landlords, they know who we are as you know it's confidential we don't you know there's nothing that goes a landlord that says HASA, it says HRA. But you know there are many brokers and landlords who you know worked with our staff for a long time, are familiar with it. We haven't' seen a disadvantage because of the other programs.

CHAIR LEVIN: Do you have any instances or any documented instances of landlords turning down a client because based on the HASA program and if that does happen what recourse does either a client or social services provider have to pursue that?

DANIEL TIETZ: So as you well know that sort of discrimination in New York City is illegal and we take that very seriously. So we have antidotal reports from clients and as was mentioned

in our June testimony we taken genuine steps to make sure the staff are aware to report when a client comes to them with a, we're frankly interested in taking cases. We have since the June hearing worked with our colleagues the City Commission on Human Rights we're about to issue a flyer for all the staff that can be given to all of our clients regards to source of income discrimination, how to report it both to us and to the City Commission on Human Rights. We're creating poster that will go up into centers very soon with the same messaging around sorts of income discrimination, so we're taking genuine action to make sure that both our staff and our clients know that it's illegal and what they can do to report it if they feel that they been discriminated against.

CHAIR LEVIN: We have anecdotally heard some concerns that… that there's not as an optimal level of coordination between HASA HRA staff and not for profit providers that are working with clients. Can you explain how the coordination, what's… what's the kind of nuts and bolts coordination between a client HASA case worker and not for profit provider

that's helping them with their housing and other related services?

DANIEL TIETZ: I'm not sure I understand how you mean coordination?

CHAIR LEVIN: The level of communication, we had heard that there were on some specific instances that their receiving, that clients are basically receiving contradictory advise or that there's, that there's, that there's, that the level of communication between an HASA caseworker and not for profit provider are, it's just not optimal that there's, that they don't have the kind of you know coordinated kind of set, set communication between again the HASA caseworker and the not for profit provider. I was wandering how, what's the relationship between the caseworkers and the not for profit providers?

DANIEL TIETZ: Well I can give you a general answer, certainly if you, if you are provider specific instances please tell us I have (inaudible) were always happy as it come to Member Johnson noted to take a particular instances and I think that especially useful in terms of training and oversight and to degree just be disciplined with regards to

employees. So you know in addition to the… the LGBTTY cultural competency training that were doing right now we're also working on a broader customer service training after for all HRA staff including HASA. But I would think the general answer is that our case management, our case workers were in the business of benefits and services, public benefits and services. And then we refer clients to other providers for everything else. So if they need psychosocial case managing, mental health services or substance abuse treatment what have you, we refer folks. The degree which clients choose to follow up and engage with some other provider of course up to them. We do our best to make those connections for people and to refer them to other providers but I think it's that there are individual instances in which there is some lack of communication or… or if there are instances in which a not for profit provider thought that a HASA caseworker supervisor had given core information as regards to public benefits or services, please we love to know that because it in that way we can then take some action to correct.

COUNCIL LEVIN: I want to ask a couple of questions around Int. No. 935 which is the bill that I'm sponsoring. Do you know that last time that the policy and procedure manual was updated?

DANIEL TIETZ: There are often updates to the you know to a section or two or three you know for example last June/July we decided that… that folks didn't single HASA clients didn't need to reside in studio's alone, which had been the previous policy and we said that you know one bedrooms were fine we don't have an opinion it's really largely about the cost. So if the cost within the guideline or acceptable under the case by case financial analyst, the size of the unit wasn't our concern. So those kinds of things happen with regularity, I'm not sure what.

CHAIR LEVIN: And that's, and that's would that, would that be like official change to the policy and procedures or is that a, is that a in terms of a manual itself or is that just a internal policy change.

DANIEL TIETZ: Yes that's a policy change.

CHAIR LEVIN: In terms of the manual itself is it, do you know when the last time that's been updated? And what the process now for how that updated, do you, do mentioned you referenced in your testimony that… that there is a… a public response of some of kind that's… that's called for in terms of some of the things that the bill is calling for and you mentioned that there may some redundancy in terms of that, so in terms of the in the process of updating currently policy and procedure manual, is that, does that have to go to a public process, is there a group of public input in that case when it's an official change to the what's in writing?

DANIEL TIETZ: Well certainly the HASA advisory board is there for this purpose which to have that back and forth more informally since, since the summer of 14 we also have HASA workgroups and we share so we, we you know have a lot of back and forth with a community and providers on changes in policy. You know there's the KAPPA lays out the instances in which we have to do a KAPPA hearing for some more substantial changes on and I think our as I said in our testimony we're happy to have a back and forth with you and Council about the language in the bill

with regards to what outta fit in which basket whether it a KAPPA type hearing or something other than that.

CHAIR LEVIN: So some changes don't require that a KAPPA hearing.

DANIEL TIETZ: No.

CHAIR LEVIN: What's the, I'm sorry what's the cut off there, is there is that, is that to be determined by HRA legal staff is that?

DANIEL TIETZ: Yes, we would absolutely have the Office of Legal Affairs as well as City's Law Department way in.

CHAIR LEVIN: Ok. Do you know when the last time a policy a update to a policy procedure that required a public hearing?

DANIEL TIETZ: Yes the 30% rent cap I think we did a, we did a KAPPA hearing on the rent cap.

CHAIR LEVIN: Oh rent cap. Do you know when the last time the bill of rights patients, I'm sorry the client bill of rights was updated>

DANIEL TIETZ: I don't know when, when a last approved version was, but we are working on one now, so we've been both HRA broader set of clients

rights and responsibilities as well the one for HASA are being worked on as we speak.

CHAIR LEVIN: So in terms of the advisory board I do appreciate the… the HRA being proactive convening the working group that might be able be possibly more flexible or than… than… than the advisory board but obviously the advisory board is mandated by law and… and is mandated to… to meet quarterly, is that, is that happening when… when… when you guys came in was the HASA advisory board meeting quarterly and if not why not and is it meeting quarterly now and if not why not.

DANIEL TIETZ: So let me start with the last question, yes it's meeting quarterly now and I think I acknowledged in my embarrassingly in my June testimony that it was my confusion with regards to meeting previously. So I had mistakenly understood that because the majority of the terms had expired as of the end of last administration that then there was there there and was told earlier this year, oh yes there is, so the essentially that folks continue until their replaced and so as I understand from Joanne Page who is and was the Chair that they were meeting up previously even thought I wasn't aware of

that and you know obviously were there to be helpful, were there to attend but we don't drive that train the Chair of the Advisory Board decides when the meeting are and you know and… and shares them. So were there if will some since as staff and but yes we, we've now been meeting quarterly since earlier this year and had a meeting just in the last, just before I went away on vacation. So in September and it's meeting quarterly.

CHAIR LEVIN: So… so what basically what you're saying is that the advisory boards meeting schedule is not driven by HRA at all, it's driven by the.

DANIEL TIETZ: No the Advisory Board it's the Chair and the board decides you know the that. In these you know last several meetings you know we've hosted those at HRA my assistants helps to arrange the space and time what have you but it's upon their request.

CHAIR LEVIN: And then what's the relationship between the advisory board and HASA, if the advisory board say takes the majority vote to take a position on something obviously it's within

the name of the board of the advisory board but what… what does, what does HRA then do with the advise?

DANIEL TIETZ: Well certainly you know Jackie, you Sam (inaudible)who's here as Assistant Deputy Commissioner of HASA, others of HASA staff attend meetings you know were there to answer questions and to have a back and forth regards to the advisory board agenda items and to be helpful in any which way we can. At least in the time that I've… I've… I've been here at HRA, there have been no you know particular recommendation from their advisory board to do or not do something or another, I think more an understanding of the reforms that we've… we've had at HRA. It's a back and forth with regards to you know what's… what's being reformed, what's not being reformed. I know that the, that (inaudible) Chair has been particularly interested in the idea of expanding HASA as we discussed here today and what that would mean for HRA going forward, what would it mean for HASA services going forward etc., but I don't, there haven't been, there haven't been both if you will a that I can recall of the advisory board to act or not act in some policy way in the last several meetings.

CHAIR LEVIN: Does HRA have a standing commitment to the board to provide meeting space?

DANIEL TIETZ: Oh sure.

CHAIR LEVIN: So anytime at any of the meeting whether it's a quarterly meeting or if there was to be a meeting that would be convened by an additional meeting convened by the Chair or the majority vote the members that… that they can meet at HRA.

DANIEL TIETZ: Yes.

CHAIR LEVIN: I want to turn it over to my colleague Council Member Menchaca for additional questions.

COUNCIL MEMBER MENCHACA: Thank you Chair. I just to underscore that conversation about the advisory board and how it's making steps to, your making step to move that conversation forward time and time again when I go back to district I'm working with agencies those relations are so important and going back to the board itself and the constitutes that are a part of that conversation understanding how they feel about their relationship with HRA and the board is important and not until they feel satisfied and… and I think there's a lot of good

request here that are good and fair. Will… will turn the tide in conversations with communications or turn the way communication happens with their constitutes so I just want to continue to applaud that kind of work and… and hopefully as we get more feedback and reports that things are just better with them. Now there's some testimony that I been going through that's about to come up next and one thing just popped up with Harlem United and their MRT funding with AIDS Institute and the Pilot Project. Are you familiar with the Pilot Project that Harlem United and AIDS Institute put together?

DANIEL TIETZ: Yes a little bit.

COUNCIL MEMBER MENCHACA: A little bit ok. So they're going to present and we should make sure that staff stay to hear that, I don't want take the thunder away from their testimony but how would HRA take this data that's coming out and can we see you adopting this as data or can we see HRA start funding some pilot projects as we discuss the bill, as we discuss their conversations with State as proof of concept as to what we're talking about, is that something that HRA can do?

DANIEL TIETZ: We would certainly be interested in seeing whatever results they have and… and… and work with our not for profit partners and State agencies partners to come up with something similar at… HRA I don't, we have no objections.

COUNCIL MEMBER MENCHACA: Ok and that's just helpful I think for a lot of folks are… are non-profits and our folks on the ground often take that extra step so it's risk and I think there sometimes divide with government in your just proven that it's not, which is great, so I'd like to kind of see that… that conversation happen in a productive way and for you to come and adopt some of these, some of these finding, make them your own and really allow that to be tool in conversations with the State along with us as well. So good, I'm glad to hear that. Thanks then.

CHAIR LEVIN: Thank you Council Member Menchaca. Just a couple more questions and then I'll let you guys go. And we look forward to hearing testimony from everybody that's been patiently waiting for their turn. How is it determined whether a client is in need of emergency, whether a client is in need of emergency housing, excuse me, how to

determine whether a client in need of emergency housing is placed in a commercial SRO, hotel versus a transitional congregate facility?

JACQULINE DUDLEY: Certainly the transitional housing model is preferable because it provides on-site support of services but unfortunately we don't have enough of those available and we do have a mandate to house a client present as homeless on the day he or she request housing so in the event that there aren't sufficient number transitional beds available and but we have more clients that needs housing then they'll be referred to commercial SRO. Have we are actively trying to secure additional transitional housing beds try to reduce our alliance on commercial SRO's.

DANIEL TIETZ: I would just add in a related vain that you know in particular with the 30% rent cap one of our goals is then that folks who are for example in Scatter site, I would say in particular Scatter site many a little less so in (inaudible)it depends on their status and their need today versus maybe when they first enter Scatter site or Congregant but it well as in transitional folks who got some opportunity to move on to say a private

market apartment using our rental assistance or the rent cap if they got some earned to under income what have you. We're trying to do that musical chairs in a way which frees up more transitional or supportive housing beds for those who really need them now and then that way we also then can you know avoid putting folks in commercial SRO's versus transitional.

COUNCIL MEMBER LEVIN: Deputy Commissioner you just mentioned that it's… it's preferably to… to place clients in a congregate setting and that's logical that Social Service is onsite Social Services are going to me more accessible and therefore better in some way or if you want to qualify better then… then… then what can be provided in scatter site. I that necessarily so, is that something that you see just in practice that it's generally that's the case and if so how can, how is there a way to change that equation? I mean, I… I… met with a very impressive provider that last week that has congregate and scatter site and sometimes you have the you know like a not the same not for profit is proving the services in both settings. Do we, is there, is there, are we looking at way to bring Social Services available in a scatter site

setting up to the level of congregate or is not, is that not necessarily the case? How would you characterize?

JACQULINE DUDLEY: I would honestly comparing commercial SRO's to transitional housing.

CHAIR LEVIN: Ok.

JACQULINE DUDLEY: With commercial SRO's are normally for profit entities that are not run by, run by a not for profit and there are no services provided at all.

CHAIR LEVIN: Oh ok. So

JACQULINE DUDLEY: There are linkages to CBO's but no on-site services at all.

CHAIR LEVIN: So you're in the SRO's there aren't, there aren't.

JACQULINE DUDLEY: No on-site supportive services that all, which is why we're trying to reduce our unreliance upon those.

CHAIR LEVIN: But those, but… but if a client is placed in a, in a SRO for profit SRO, they're still, they still have relationship with the social services provider right through HASA, is that?

JACQULINE DUDLEY: Yes, they still have HASA case manager.

CHAIR LEVIN: An HRA HASA case manager.

JACQULINE DUDLEY: Right.

CHAIR LEVIN: But they don't have the… the… the ancillary services, the (inaudible)?

JACQULINE DUDLEY: Well we require, we require all of SRO operators to have linkages with community based organizations so there are community based organizations that regularly have relationships with the residence in the SRO's. And from our prospective from our primary goal to try to get them out and try to get them whatever support services or whatever additional help or support that they need to try and get them into more permanent housing settings. That's what we look to the CBO's to help us to do with and because and one of the reason we do prefer the transitional model is that they do have the on-site support services and one of their mandates is to try to transition them into permanent housing I think within 180 days.

CHAIR LEVIN: Ok.

DANIEL TIETZ: We should also just note that the folks who, our obligation of course is to house those who are homeless the same day that they come. You know folks have a choice about whether

they wish to be engaged in the other services in to which we would refer them. So we might think that they… they would benefits from subsidies services and treatment so that they may benefits from a mental referral. Whether they choose to engage it or not is entirely up to them. And our case workers will believe me press the issue with within they meet with them but at the end of the day folks get to make a choice about which services their engaged in and will house them either way.

CHAIR LEVIN: So but every SRO has… has a CBO that their affiliated with through HASA and does every SRO client place, SRO client have like do they have like a… the have like a HASA case obviously but do they have a case with that not for profit? Like if I went, if you went over like the not for profit do they have like a, like a, like literally a case open for each HASA client that been in the SRO that there that not for profit is affiliated with?

DANIEL TIETZ: That's the intention but again I mean they have a.

CHAIR LEVIN: Voluntary.

DANIEL TIETZ: That's right… right… right.

CHAIR LEVIN: But ok and how many of those contracts are there in terms of those… those CBO?

JACQULINE DUDLEY: There not contracts necessarily, there just linkages where they'll provide at the convenient base organization with access to come in and try to screen and access, you know who may benefit from their services. And they get it completely voluntary and it's sometimes it's not a cart type of situation, they may take certain and services and they may decline others from the CBO, but at least if they choose that they do get involved in some small way at least that's a door in, you know but that's the way to… to engage the client and maybe come back later on and peak all for an additional services.

CHAIR LEVIN: And if the client is seeking the services there readily available, they don't have to, if there should be no reason why a client seeking services wouldn't be able to get the services.

JACQULINE DUDLEY: No I… I HASA clients for the most part have an access to a variety of community based organizations often who are coming to us repeatedly asking us for help in recruiting and

getting them referrals so if we, if there are clients out there who need assistance and who are looking you know, there are no shortages of programs who be more than willing to help them.

CHAIR LEVIN: Last question is… is there an update on when the master emergency housing RFP will be issued?

DANIEL TIETZ: It was.

CHAIR LEVIN: Ok sorry.

DANIEL TIETZ: And it was closed. So there, we're reviewing the proposals now.

CHAIR LEVIN: And what's the size of that overall RFP?

DANIEL TIETZ: I don't recall off hand. I can get it to you.

CHAIR LEVIN: Ok. Ok, well thank you both very much for your testimony, I we look forward to hearing more news in the coming weeks, we very much appreciate your cander and your willingness to work with us under these two pieces of legislation and we are hopeful that the next time we meet that we will be discussing how, how the implementation of HASA for All is going. But thank you very much for

your time and will… will call the first panel for testimony. Thank you very much.

DANIEL TIETZ: Thank you Chairman Levin.

CHAIR LEVIN: Jezwah Harris from New York Law School, Dr. Alvin Ponder, HIV/AIDS Committee of the National Action Network, Chris Mann, Partnership for the Homeless and Michael Czakes from GMAC. Will take a 3 minute break. So sorry 3 minute test, were going to keep testimony to 3 minutes. Will also take a 3 minute break. Just for reference here we have to clear the room by 1:00 p.m. so that's why we're going to be on 3 minute talk for testimony.

[pause]

CHAIR LEVIN: Ok whoever wants to begin. Please turn on the, see your red light.

DR. ALVIN PONDER: I'm Dr. Alvin Ponder, Chair of HIV/AIDS Committee with the New York City Chapter of National Action Network. The HIV/AIDS Committee of the New York City Chapter of the National Action Network (NAN) lead by the Reverend Al Sharpton respectfully submits testimony regarding the expansion of benefits to poor people with HIV in New York City. The NAN HIV/AIDS committee is a health related advocacy group that strongly urges the

adoption and the signing into law bill number 684. Which of course in aimed at reducing the scorch of HIV. Governor Andrew Cuomo's plan to end the AIDS epidemic in New York State by the end of the year 2020 is a worthy formal for improving the lives of African American and Latino New Yorkers and community disportionaly affected by HIV and AIDS. New York State has developed a blueprint to work towards the goal to end the HIV epidemic over the next five years by decreasing the number of new infections from the current approximately 3,000 to below 750 new HIV infections annually such that it is below the epidemic level. Statistically this would be the end of HIV in Harlem; statistically this would be end of HIV in the South Bronx. Many opponents of this excellent plan argue that it's enhanced housing would leave the poor to swap good health for HIV in order to secure the housing benefits of this bill. In other words option will entice the poor to trade good health for better dwellings. The poor is not stupid enough to hasten the end of their own lives simply because taxpayers underwrite the cost of treating their lives. There is no evidence that New York City or state policies around housing has every

contributed to people getting infected with HIV. New York has many kinds of support for people with HIV infection and the general Medicaid population. The fact that bill number 684 exist at all is an indication that others of us realize that HIV is a community problem and that community resources must be employed to solve this problem. We are indeed the keepers of our brothers and sisters are kindred in need. As we embrace them with expanded care we contribute the health and wellness of the total community. The passage into law of bill 684 then is a must for those of us who are proud to claim New York as our home, it is in support of this pride that I stand before this august body in the name of the HIV/AIDS Committee of the New York City chapter of the National Action Network, as the Chair and as the member of the Health and Human Services Committee of Bronx Community Board #10. It is in support of this pride that I respectfully ask that the Speaker Melissa Viverito and the New York City Council and Mayor Bill De Blasio strike a blow with the adoption and signing of bill 684. Thank you for the opportunity for me to advocate for my brothers and sisters.

CHAIR LEVIN: Thank you so much for your testimony. Thank you.

MICHAEL CZACKES: Good morning, I can go next. My name is Michael Czaczkes and I am the Director of Policy and Public Affairs at the Gay Men's Health Crisis. GMHC is the world's first AIDS service organization based here in New York City providing a wide range of comprehensive services, including a hot meals, benefits enrollment, healthcare advocacy, case management, legal assistance, HIV counseling and testing. In 2014, we served more than 9,000 clients from throughout the five Boroughs.

In addition to direct services, we also provide public policy advocacy which is why I'm here today. We will look back at our 2008 City policy agenda which shows support for the expansion of benefits from the HIV/AIDS service administration known as HASA. Since then, we have continually fought to expand benefits to allow more New Yorkers to qualify for housing, nutrition, and transportation benefits because we know that housing is key to ending HIV and AIDS in New York. Today this effort is known as HASA for All something we fully support.

The problem is that current HASA regulations require those who receive benefits to have an AIDS diagnosis or symptomatic HIV infection, mean that a whole group of people who are HIV positive do not meet the medical requirements and cannot receive benefits. While these regulations have remained unchanged, we have seen treatments reducing the number of people who progress from HIV positive to AIDS, so even a larger donut hole of people who cannot access these services

In turn, we've have heard stories throughout the years of New Yorkers stopping their treatments in order to become sick enough to qualify for HASA. Sadly, these stories are not surprising given the cost of housing from the Rockaway in Council Member Richards district to North Brooklyn in Council Member Levin district. Those affected by HIV and AIDS in New York City must be part of the current dialogue on city's affordable housing shortage.

GMHC, along with members of Governor Cuomo's Ending the Epidemic Task Force, know that in order to achieve and maintain viral suppression, which is the clearest indicator that appropriate medical care is being provided, a person with HIV

needs a host of non-medical resources. Persons with HIV who lacks jobs, housing, financial resources, and adequate insurance are less likely to achieve improved health outcomes. To answer a question asked earlier about the number of people who are out there who are not on HASA because they are not eligible. There are estimates 10,000 to 15,000 people according to the Governor's End the AIDS Blueprint that was released a little while ago.

In addition in closing in addition to HASA for All, Int. No. 935, from Council Member Levin creates a new advisory board with a membership that include people with clinical symptomatic HIV illness. In general, we believe participation is essential in public policy decision making and delivery. And that this board will give those living with HIV and AIDS a more direct voice regarding the provision of benefits and services. Thank you to Chairman Levin and the Committee on General Welfare for hosting today's hearing.

CHAIR LEVIN: Thank you very much Mr. Czackes.

CHRIS MANN: On behalf of the Partnership for the Homeless, thank you for the opportunity to testify in favor of the proposed legislation.

CHAIR LEVIN: Speak a little bit closer to the mic.

CHRIS MANN: Sure, my name is Chris Mann and I am a health advocate at the Partnership. In that role, I have worked extensively with low income, HIV positive individuals providing health education to promote increased health outcomes. Despite the value of these services, finding a permanent place to live is often the first priority of our clients and at the Partnership, and at the Partnership for Homeless we believe in housing first model. When it comes to connecting a client with housing, their HASA eligibility is one of the main factors that will determine the difficulty they experience finding a home. It's clear that HIV and homelessness are deeply connected issues. Studies indicate that as many as half of individual with HIV and AIDS are at risk for homelessness. Furthermore, homeless people experience HIV infection at ten times the rate of the general population.

Housing status is one the strongest predictors of health outcomes for people living with HIV and AIDS. In particular there is a need for permanent housing and not just shelter. If a client is HIV positive and not eligible for HASA, the likelihood that they will find permanent housing within a reasonable timeframe is greatly diminished. For many, this means longer stays in the city's shelters where their health often deteriorates due to poor sanitation and other adverse conditions.

One of the main issues created by life in the shelter or on the street is its effect on treatment adherence. One client reported that finding a confidential space to take his medications was always an issue in the shelter. This made it nearly impossible for him to develop a consistent routine, which would not be an issue if he had permanent housing. Lack of adherence leads to higher viral, leads to a higher viral load and a higher risk of transmission.

Housing status is a discussion that I have with all my clients. In one such discussion with a client who was HIV positive but not HASA eligible, I asked him where he was staying. He

stated I'm a gay man in the age of grinder, I can always find a place to sleep, implying he was having sex in exchange for a roof over his head. His response highlights one of the many negative consequences of denying HASA to individual who are HIV positive but are not yet considered sick enough to be eligible. This behavior is risky, particularly for someone who is living with a compromised immune system. By expanding HASA benefits to all low income people living with HIV, people like my client will have a much better chance at securing permanent housing. By having a permanent place to live, he would no longer have to choose between sleeping with a stranger and having nowhere to sleep at all.

Thank you again for this opportunity to testify and I welcome any questions you might have.

CHAIR LEVIN: Thank you for your testimony.

JEZWAH HARRIS: Thank you for giving me the opportunity to talk to you today about an issue of great concern to me both personally and professionally.

My name is Jezwah Harris and I represent New York Law School's Legislative Advocacy Clinic and

myself. I have some experience in this issue on multiple levels. I am a student attorney, a registered nurse and a HASA client. So I have, I have a little skin in the game as you will.

I think thank Council Member Johnson for his leadership on this issue and all the other Council Members who are working to address an underserved demographic in New York City's HIV positive population and to confronting the lack of transparency on the part of the HASA division of the New York City's HRA.

Many of you may be familiar with Governor Cuomo Blueprint for Ending AIDS. New York City has accomplished only a 3% greater decrease in the rate of new HIV infections than the State of New York. This is inadequate progress for a city that has an entire agency devoted to serving symptomatic HIV and AIDS clients. We can and must do better.

One barrier to real progress is that the City of New York is only serving the symptomatic population. If we are to reach the goals set by Governor Cuomo earlier this year we must reach a broader population, reach them earlier, and provide all necessary supports. We must get all HIV positive

individuals into available services immediately after testing positive and we must assist in the adoption of HIV PrEP or Pre-exposure Prophylactic Therapy among high risk populations. We have to keep patients on anti-retroviral treatment, we have to keep the compliant to achieve a substantial reduction in new HIV infections.

The World Health Organization and the Centers for Disease Control are now in agreement and recommend that anyone who test HIV positive should be treated immediately because early treatment keeps those with the, with the virus healthier and reduces the risk of transmitting the virus. Early and preventative treatment can reduce the transmission of HIV up to 99% with up to 94% of those on treatment reaching undetectable sanguineous viral loads.

Frankly there is a lot of work for New York City to do, and it can start with the Council. Two major hurdles with ART initiation and compliance are a single point of access and stable housing, both of which HASA should provide for all current HIV positive person and those who are diagnosed in the future. The single point of entry is crucial because it gives those in need of both medical and social

services a fixed point to the referred to by the diagnosing healthcare provider or collaborating allied health professionals. The HASA client referral numbers from June of 2015 show that approximately 50% of all HASA clients are self-referred. New York should be sending the newly diagnosed to HASA not leaving the patient to conduct a search for available help. The single point approach provides us an opportunity. It will be a place where those at high risk can seek assistance with other services such as Medicaid or other government programs.

On the housing side, the Council can start by addressing transparency issues at HASA that make it difficult to navigate for clients. HASA currently has programs in place for both ongoing and emergency housing. These programs take two primary forms as either a HASA units leased or privately rented market rate apartments. HASA spends an average of $1958 per month on 5701 leased units, whereas the 23,000 clients with privately rented units receive between $480 and $1100 in rental assistance per month. However, HASA does not make the criteria to get the $1100 available to clients

and the approval process is arbitrary and shrouded in mystery, meaning people can be receiving vastly different supports for no obvious or justified reason.

The lack of stable housing access not only forces HIV positive people out of their homes, but given the current demographic makeup of the newly infected, it also has a population transfer effect. This effect appears to be racially discriminatory and forces people to the outer boroughs where there are fewer, far fewer supports available. Even though a good number of these clients should qualify for the 30% income rent cap that was enacted last year, it is not currently being applied to all HASA qualified participants as the state law intends.

I want the Council to understand the positive impact that HASA will have, HASA for All will have and the greater transparency it will have on the currently marginalized and underserved HIV positive population.

Today I ask for your support for both the HASA for All bill and the Division of AIDS Service bill. Thank you for your time today.

CHAIR LEVIN: Thank you very much for your testimony. It was very thoughtful and we will make sure that we will take your recommendation into account as we move forward with these two pieces of legislation I want to thank this panel you're your thoughtful testimony for being here today and for your advocacy. I believe strongly that the… the reason why we are at the state that we are at today is because of advocacy from communities and compliance who and providers who have fought the good fight for a number of years and we are in a position today to be able to act on that but we wouldn't be doing so if it wasn't for the years of advocacy that went into it so, thank you very much for you're testimony thank you.

CHRIS MANN: Thank you.

CHAIR LEVIN: Call the next panel Marcelo Maia, James Edstrom, Kathy Kenlis, Village Care and James Lister, Vocal NYC, Vocal NY, sorry.

[pause]

CHAIR LEVIN: I apologize if I got anybody's name wrong. You have the opportunity to correct the record. Anyone wants to begin, go ahead.

JAMES LISTER: Thank you James Lister from Vocal New York. I'm testifying for both of them actually but I'm going to concentrate on 684. Personally being a HASA client and testing positive in 1989 this would have helped me a great deal. Because of the current situation the policy resulted in my bankruptcy, isolation and disintegration of my quality of life. In 89 I tested positive, in 1992 I had my lowest t-cell count but I still didn't qualify and in 2002 I finally had the two (inaudible)infections that would qualify me for HASA. By that time I was pretty bankrupt, I had to isolate myself not spending money on anything because I was determined not to be homeless and because I lived in… in my own apartment versus losing my apartment going through the system, I was not protected by the 30% rent cap until of course now. The we know the temporary and emergency housing is more expensive. We know that temporary and emergency housing is sub-standard. So therein lays a very obvious decision to keep people out of temporary emergency housing because of both of those reasons we keep them in their own home. The… the policy of imposing the budget of 276 on clients is unrealistic. Having

lived on that for quite a while and while I was grateful for it… it contributed to the disintegration of my quality of life and also to my isolation. I do want to speak about HASA case workers because I've had several or many I guess. One did not speak English and I don't speak anything but English and she also didn't know that Wednesday followed Tuesday. Another was a drunk. (inaudible) two of mine had been so empathetic and knowledge that I… I mourned the day that they moved on to something else because I knew that my chances of getting a replacement just like them was going to be next to nothing. I also think that it's important that the eligibility rules and what benefits are visual for people who are HIV positive even though they may not qualify for HASA benefits, need to be placed in where HIV positive people congregate, where they can get information like GMAC that would be a place that I would say that they you know would know that it exist. Because I really didn't know, you know I was not involved in other everything. I really didn't know that was even an option for me. So I will thank you.

CHAIR LEVIN: You could keep going if you have a little bit more.

JAMES LISTER: No that's all right.

CHAIR LEVIN: Thank you very much for your testimony.

TASSY CAROLY: Good afternoon my name is Tassy Caroly, I'm a case manager for a non-profit Village Care. So as a case manager the my firsthand experience with clients especially a lot of them that are in shelters that are a-symptomatic you know their taking their medication and they feel like their, their kind of left on the waist side and providing medical case management the biggest thing is housing. So a lot of them feel like you know what, I'm not going to take my medication anymore and I'm going to try you know make my make me sick, make myself sick so I will probably do risky behaviors you know, go into sex trafficking and do all these things just to have my voice heard for HASA. So I think that's the main point when it comes to housing, it equals health, your healthcare because a lot clients in order for them to for us to meet them half way they want to be stable and housing is a big component in New York City that affects clients. Also I wanted to talk about clients that do have HASA, it's hard for us as the case managers that are helping to provide

medical case management making sure they go to their appointments it's the linkage is very hard so sometimes you know a lot of the clients will say I haven't heard from my HASA worker, I'm trying to reach my HASA worker and then me as the case manager is trying to you know collaborate with the HASA worker. And they don't answer phone calls, so now were doing the medical park and the housing part as well and it would be nice for us to kind of link together. If I'm doing the medical they should be able to do the housing and we can meet halfway and I think that's the hardest part in terms of collaboration, I'm not sure if you know a lot of them say the language barrier like she was saying the language barrier or they don't know who the CBO are that are working with client that are receiving services and what we do. So I think a lot of those things are a big factor in actually providing quality care.

CHAIR LEVIN: Thank you. So just to follow up I mean when I ask, I was asking Mr. Tietz and Deputy Commissioner about this and I think that there is an opportunity for greater collaboration between case managers within the not for profit

organizations and… and HASA so that there's that… that… that's something you know that can always be improved but we what I'd like to see from HRA is some concrete steps that they can, that they can instigate or you know start on where we can see some greater collaboration of communications.

TASSY CAROLY: I agree.

CHAIR LEVIN: Do you think that as a case manager you think that could be helpful?

TASSY CAROLY: Yes that's a big barrier, big barrier.

MARCELO MAIA: Hi, Thank you New York City Council Member Stephen Levin, Chair of the Committee on General Welfare and Council Member Corey Johnson, Chair of the committee on Health and the New York City Council Members here present for scheduling this hearing on HASA and for this opportunity. My name is Marcelo Maia, I am facilitate the ACT UP New York HASA Group.

Our Mission is to address HASA policies that impact clients, to update the Rental Assistance Program grant to reflect local real estate market values and other issues affecting People Living with HIV and AIDS.

The Group is spearheaded by HASA clients, representatives of major community based organizations working with people living with HIV and housing are also members and receive notes from our meetings.

On the hearing of June 24, 2015, we distributed a list with 42 issues and 12 proposals to improve HASA. This time, we would like to focus on the proposals which are now totaling 17. Again do to time constrains I'll read the identified as priorities and they include, they include the changes on HASA eligibility criteria which we endorse and HASA advisory board, which we support.

Proposed is first is the rental assistance grant that must be updated to reflect the real estate rental market values of the neighborhood of client residence. We argue that the HUD guidelines limit of $1,100 for a 1 bedroom are too low and have not been updated since 2002, while New York City rents is skyrocketed. Because of that, clients with permanent housing are losing their homes and stay on SRO's are much longer. We understand that even though those are guidelines, they represent the actual limit for clients looking for housing.

As recommended by to the Task Force to end the AIDS epidemic in New York State. Update the rental assistance rates provide through the program to provide rental assistance in line with the market rental rates in localities.

After 20 years of republican mayors, HASA needs the structural and philosophical reforms. HASA eligibility must be grant to all people living with HIV who need housing. This proposal is being addressed and by the proposed amendment to Local Law 49. Case workers must be certified by HASA and evaluated by clients. HASA to establish a program that will assist clients who need it, to get a GED or access CUNY to finish or have a college degree. HASA CAB to update then displays the Client Bill of Rights and the list of client's entitlements in every center, in every center. I'll just read the conclusion, my time is up.

We understand that permanent housing is fundamental if people living with HIV are to be tested, connected and remain in care, you start treatment, suppress viral replication, achieve maintain an undetectable viral load and stop HIV transmissions. It is also known that New York Task

Force to End the AIDS Epidemic has recommended that HASA like services be extended throughout New York State. We must not replicate a model which that has known problems before we correct them. We will work on transforming the concept of permanent housing into that of a home for people living with HIV and AIDS in New York. Thank You.

CHAIR LEVIN: Thank you Mr. Maia.

JAMES EDSTROM: Thank you Mr. Maia.

JAMES: Ok My name is James Edstrom, I'm a HASA client and I'd like say right off the back that HASA is the most abusive agency the City has. I'm not going to beat around the bush here ok. In HASA the minute were diagnosed with AIDS were under house arrest. That's what it comes down to. We're required to have case workers, we're required all these things that are required of us and if we don't do it, we're subject to eviction. I am currently in Supreme Court with HASA providers St. Nick's Alliance where abuse is including; rape, breaking rent stabilization laws, harassment, living with rats and mic, abuses by landlord and case workers and breaking the Americans with disabilities act which states equal or better housing. Most of the HRA's providers

break these laws and the HRA refuses to do anything about it even when proven. These housing contracts the City signs with these providers are illegal. There are already rules in place for the HRA for people living with AIDS. They mean nothing to the HRA and the HASA staff. There are no safeguards in place to protect us. There is assistance for us to complain, there is no system for us to complain and call a provider into the HRA but the provider can call us in for any little thing called the step process. Step one, step two, step three then an eviction. When you are called to one of these step meetings, even when you prove you are right, the HRA sides with the provider. This is wrong. After I begged for almost three years for the HRA to do something about the abuses, they ignored. When I finally had it I was forced to go public in the New York Daily News and say I have AIDS and tell about the abuses. At the same time I filed a lawsuit against the provider in Supreme Court. This did not even make the HRA or the provider do the right thing and fix the abuses. In fact it outraged the HRA and St. Nicks Alliance and abuses became worse. My lawyer informed the HRA and St. Nicks Alliance that

since we were now in a lawsuit all actions against me was to stop as required by law. It did not. I not only complained about the abuse for the landlord. I complained about the drugs in the building in St. Nicks Alliance not only refused to address the drug problems, they refused to give the videos to the police of the drug deals I witnessed. If anyone recently read the story of the big heroin bust in Brooklyn a few weeks ago, the woman accused of money laundering for the drug operation was the St. Nick Alliance property manager, Hedy Cadello (sic). Her son ran the operation. St. Nicks operates or owns around 80 buildings in Brooklyn. The HRA knowing there was ongoing lawsuit still allowed St. Nick Alliance to follow step one against me and when I attended with my lawyer and proved all the allegations were false the HRA still ruled against me. My lawyer once again informed the HRA that since there was an ongoing lawsuit against St. Nicks Alliance it could not allow any more step meeting. Shortly after the HRA called me into a step two meeting for false charges. Once again my lawyer and I went to this meeting, at the meeting we proved we were living with mice and rats, we proved we were

being abused and we proved St. Nicks Alliance forged my lease agreement. Their testimony from their own HRA employee who was at the lease signing and she said the leases were forged that I never agreed to certain things like meeting with case workers and still the HRA ruled against me. There were eight people from the HRA and HASA in that room against one person, me. Some HASA facts and I know my time is up. When you go to HASA, when you got HIV and AIDS you are labeled as drug addict and an alcoholic even though you are not. This is a fact. I called Robert Doua (sic), I got him on the phone, the former Commissioner, he said they do the that in order to get federal funding. I had several phone calls for former Deputy Commissioner Frank Lipton (sic), they admit that we are labeled as a drug addict and alcoholic who's been in rehab in order to get extra federal funding. This done to all of us in the HASA system. HASA system is broken, HASA needs to be fixed. I support this bill but it need to go a lot lot further because we are being abused by HASA and nobody would do anything about it. Thank you.

CHAIR LEVIN: Thank you very much sir for your testimony and thank to this panel for your

testimony. We a, again we greatly appreciate the feedback that get particularly from clients where were able to understand and get a greater insight into the reality, you know what's happening on the ground and we appreciate that very much as that is helps us as a governmental body to look towards additional reforms, things can always be better. There is always room for improvement, nothing is in a you know perfect state even if we implement HASA for All there's still going to be improvements that need to happen within the system so we greatly appreciate your testimony. Thank you very much. New panel Reginald Brown, Vocal NY, Ivan Perez, Vocal GMHC, I'm sorry Anthony Williams, Care for the Homeless, Annie Soriano, Friends House.

REGINALD BROWN: Good afternoon Chair and all that are present. First I'd like to say thank you so much for following up on the fact that even though I'm on the HASA advisory board I had not been notified. I've now been notified so I will be dually attending the meeting. And I can say that if no recommendations have been made because.

CHAIR LEVIN: I'm sorry can you identify yourself.

REGINALD BROWN: Oh, I'm sorry I always do that. I'm Reginald Brown, Vocal New York and as I said I at my previous testimony in June I said that I was on the HASA advisory board and I didn't know anything about meetings, well thanks to the testimony I now know that I am on the board, I've been informed of a meeting, I was not able to attend that one meeting and if no recommendations have been made is because I've not been in that meeting because I have a list of (inaudible) not only from Vocal New York but from Act Up and some other members of the community to have things that need to be done. I'd like to read also I'm here to support the Int. No. 684 because HASA for All is a no brainer. The point is if you are sick you need healthcare and we point is that we want to keep people healthy if they are not sick. But I'd like to read a personal testimony from a friend of mine who cannot be here and this is what activist do, they speak up for those who can't speak for themselves. Hello my name is Judith Gore, my journey with HASA is been riddled with more negativity then should be at Greenwood Center in Brooklyn. Regretfully I am now homeless with no fault of my own. I have not abused the system, I

have not… not in arears on rent nor have I abused property. In short, my landlord sold his building where I have been living for nearly seven years. The new landlord not renting to HASA clients or low income or middle income. I mean that's a flagrant violation right there. The building is in Brooklyn only had three units in it and I was the last tenant standing because I hadn't found a new apartment. Camba (sic), Camba is a housing provider a service organization diligently searched for, searched for a place for me. I readily understood that I could not and would not stay there long enough to recognize that I had a right to appeal to housing court to show cause to get a little more time in housing court that I thankfully got to extensions. Final eviction date was September 3rd even though I could have shown because maybe to get a few more days, however, the HASA caseworker supervision kept needling me. I kept getting different pre-eviction housing dates from my case worker and filed with the legal until I relented at my case workers assistance that it was mandatory. I moved out, put my stuff in storage and under the insurance that it would be temporary housing for me that day. I set at the HASA office the day I moved

out all of my stuff in storage, keys now properly in the new landlord hands and sat in the HASA office with my luggage for immediate move 10:00 a.m. to 4:30 p.m. September 14th. Staff was told that I should not have been moved and I should not have told that I moved because there was no place for me. My case worker Ms. Negron and Supervisor further reiterated to me that (inaudible)of no temporary housing for me. I was then asked to, I will, I will be brief. I did not have anywhere to go even though I had resided in New York since 1984 and I've been employed by the New York City Department of Youth and Employment. He is now currently couch surfing cause he has no family here so this is someone who is been gainfully employed you know (inaudible) but the landlord who bought the building said he does not I mean I guess we can get that on record or something. He does not, he or she does not rent to HASA or low income people. So he's now couch surfing, he… what he's my age so this should not happen. HASA for All is a very good idea but as previously said that it's a lot of stuff that needs to be done. I'm a HASA client, thanks to HASA I'm still here. I'm… I'm… I'm virally suppressed but even with that if we're going make

this HASA for All these things need to be done and the cultural in the HASA needs to be, needs to be humane, they need to treat us like people and I am on under house arrest. I have a case manager in supportive of housing comes to me twice a week. She happen to call me when I was out of town and she, this is a new case worker and she said, well I'm going to have a meeting with you the next day, I said well excuse me I can't do it cause I'm out of town, what do you mean you're out of town, what (inaudible) yeah I'm out of town, I said well where are you going to come back, I said I'm not going to come back for a visit that you said I have to have to a mandatory visit week that's on you. So I said I'm not leaving my Las Vegas to come back and (inaudible)I sent a letter, sent a very nice letter to St. Nicks saying that you know first of all she needs to identify herself and tell me that she's a new case worker and not just tell me she on it making appointment but like I said the way that they treat us is like, is like house arrest. I'm going away again so I've now written down everything I'm going in but the point is I'm not on parole and I'm not on probation, I'm a grown man. Thank you.

CHAIR LEVIN: Great that's an important point.

REGINALD BROWN: Oh St. Nicks Alliance is the provider the same provider and I've been denied a pet because they say that I have a pet and I only realized that the ADA says I can have a pet, guess what I'm going to get a pet. Because… because the pet is a psychological thing to be that brings me more comfort than having her come to me twice a month and ask me the same bloody questions.

CHAIR LEVIN: Do you want a pet? You should be able to have a pet.

REGINALD BROWN: Absolutely thank you.

CHAIR LEVIN: And also I mean that… that's the issue of… of the your encountering of… of you know being able to go away and be able to go on vacation and that's important, that's a vacation is as important mental health as having a pet.

REGINALD BROWN: And I am aware that if I go away for more than 30 days I'm supposed to let you know. Ok I can deal with that, but I've not been on vacation in forever and I needed this time to heal and get some spiritual healing which I now have and I'm ready to come back and keep butt and take names.

CHAIR LEVIN: And just one other suggestion is with, within the advisory board setting I mean it's important that… that you know that's there's a forum where you can bring that and it's official and that it has minutes and that the recommendations are posted online, that's why we're doing 935 so.

REGINALD BROWN: Thank you.

CHAIR LEVIN: Please… please stay with it and… and make sure that… that board is… is doing the job that it's intended to do. Thank you.

IVAN PEREZ: Hello my name is Ivan Perez, I'm a local member and a GMHC client. I hear a lot about HASA when we talk about HASA sounds health. Unfortunately it's doesn't work for everybody like myself. Being an HIV is hard to go through the day. Got to deal with the stress and depressed. HASA won't take me because I'm not sick enough and I don't want to… to the point. But that's why I need help, that's why I need HASA and that's why we need HASA for All yesterday.

ANNIE SORIANO: My name is Annie Soriano and I am the Executive Director of Friends House in

Rosehill, we are a permanent supportive housing provider for HASA clients.

I'd like to thank the City Council's General Welfare Committee for giving us this opportunity to testify today about HASA as well as legislation that would expand the benefits that HASA provides to include financially qualified HIV positive people.

I am here today to testify in support of Council Member Johnson's proposed legislation. This bill goes beyond the idea of qualifying more people for HASA services. This expansion is beyond the lab criteria and the medical definitions of a still epidemic virus. This epidemic is fueled by poverty, addiction, mental illness and homelessness. It's never just AIDS. It's also never just housing. The lack of stability for these most vulnerable New Yorkers presents barrier after barrier of being able to initiate treatment, have basic food and shelter and support that would allow them to live their lives as independently and as healthy as possible.

There is currently a lack of housing particularly among our city's low income, marginalized residents who have HIV and AIDS. We

have long known as the Council Member reports that housing is healthcare. Among the interventions that effectively address complex and intersecting health and social conditions, as well as health disparities; housing is the first priority. Housing is the key to helping people diagnosed with HIV to access healthcare, remain in treatment and prevent further transmission. Beyond housing, there is a definitive need to have access for everyone in this community to services regardless of their CD 4 count or symptoms. Diminishing barriers and enhancing access to services provides a return on investment for public health. The total cost of funding this program expansion is only short term expenditure; it's a long term investment rather than a cost. The investment is not only with our people but also a financial long term savings. Parallel with our State's commitment and initiative to end AIDS, this expansion will invariably reduce the medical cost of life time of HIV/AIDS related care by reducing new infections. It will reduce the enormous financial costs of emergency room visits, hospital stays and will stop sacrificing the health of our clients.

We have learned lessons from the past and the current state of our City being the epicenter of this disease. The disconnection from HIV care is a battle of poverty. By expanding eligibility for services, together, we will be able to provide stability for low income people diagnosed with HIV in ensuring the best possible long term wellness and an increase in self-sufficiency before they get to sick. Thank you.

CHAIR LEVIN: Thank you very much Ms. Soriano.

ANTHONY WILLIAMS: Good afternoon ladies and gentleman of the General Welfare Committee and especially you Mr. Levin for giving me the opportunity to speak today. This is a very important issue to me. My name is Anthony Williams, I've been living with HIV since 2007. I also serve now as the Chairman of HIV advisory committee for Care for the Homeless and an advocate for Vocal New York. Why is it important to me for one simple reason when you say access for AIDS or services for all New Yorkers, you must stop and think about what you said. That sounds good as you say it but you haven't really thought about it because you have things that are in place

that are not doing services to the ones that are already here. So now if you expand the services you got to make sure that the services going to work. In order for it to work you know when I became the Chairman of the HIV committee for Care for the Homeless, one of the first things I said was you'll got 30 sights why we only providing services for six. So I took that upon myself to make it my goal that whatever services we got at over here in Queens, whatever services we got up here in Manhattan, I want it to go to every center that you have. Well that's the only way you going to have transparent system that you know that everybody are being fair. Here at HASA we're not having a fair shot. It's for those that can and those that can't. It's no in between it's either you can or can't. I been they sit here and tell you a beautiful story, talking about 180 days they going to this, they award this big monstrous contract to these people that's only expanding their contract every year but they're not providing any service. They need more accountability on those that they give contracts. How can you increase somebody's contract because they say they got a case worker? The city is already paying for a

case worker, already paying. Every HASA client has a case manager through the city. Why do I need to go to a shelter for you to tell me I got to go see a case manager for what? Somebody that you created a job for not a service that they're going to provide for me or any other clients. They just got a job. They coming in anything that they put forth can't nothing happen unless they go to HASA. HASA got to approve every move that you make, so why are we paying you, why you stagnating my progress. I found the apartment myself, on my own, which they're paying for a case manager and now they don't want to process it. I would like to thank you Committee Members but I would urge encourage you for bill 684, think about it and bill 935, approve those bills, they are bills that are in best interest of the public but in after all when you approve, make sure you have the transparency (inaudible). Thank you.

CHAIR LEVIN: Thank you and you know it's this committee intention to continue to have oversight hearings on HASA as an overall program so that we're just not stopping with the passage of these two pieces of legislation. We intend on… on taking the long term approach of oversight and making

sure that the services that are supposed to be getting to clients are in fact getting to clients and in an effective way and that no client is denied or lack services if he or she intends… intends to get those services. So thank you very much for your testimony. We look forward to working with all of you. Thank you very much to this panel. Council Member Johnson you have anything you want to add? Final panel, Jennifer Flynn, Vocal New York, Clarence Henderson, Boom Health and Jose Perez, Trans Justice.

JOSEPHINE PEREZ: I'm sorry I'm Josephine Perez.

CHAIR LEVIN: My apologies Josephine I just read it (inaudible). Whoever want to begin testifying go ahead.

CLARENCE HENDERSON: Hello, hi my name is Clarence Henderson. I've been living with, I have a AIDS diagnoses since 1991. I work with Boom Health as an Outreach Specialist in Prevention Department. I belong to many organizations, many advocacy things but I advocate to a lot of organizations but I'm not here to carry water for any of them. Ok I'm here to express my point of view as a person that's out in the field every day. Ok that see the enormity of the

numbers and the needs for HASA for All. However, there is a accountability that needs to be recognized because it has to fiscally feasible to happen. This also will involve the accountability of those documented and undocumented people who are must be willing to advance a pass the citizenship in order to obtain those benefits. The need for expanded services from HASA in my view, should be towards utility security. If it can be attached to the housing plan as it exist now because there are people who still have to pay Con Edison. If there can be something in place to ensure that their lights don't go off and they don't wind up living in a house of wax because they drop the ball on giving it's payment to Con Edison for whatever reason ok. That should not happen because sometimes they can't get out that whole ok. And sometimes their living in a house of wax and candles and things like that for extended attached period of time. There should be an educational priority status giving to people who are undetectable and have been undetectable that are coherent and compliant and want to advance their living state of dignity for a while. My mentor who's had AIDS, a AIDS diagnoses and is coherent and

compliant and undetectable recently went to for to get his blood work and his blood work came in as undetermined for his diagnoses. This is comparable to what was called a false positive and the onset of living the HIV and AIDS experience but he far along in that. Perhaps this is an anomaly or perhaps this is better things to come. These things in place to advance a person that wants to (inaudible) academic or work and make money should be in place. Thank you.

JENNIFER FLYNN: Good after noon my name is Jennifer Flynn and I'm the Executive Director of Vocal New York and thank you so much for this opportunity to testify and thank you for keeping HASA on the agenda and I just want to say thank you also for your leadership in introducing these two very important bills. Vocal is a membership organization lead by primarily low income people living with AIDS. Most of them have been homeless or are currently homeless. We also convene a trade association of nonprofit housing providers that are actually the solution to homelessness and that contract with HASA. Our organization again whole heartily supports Int. No. 684 we also whole heartily support any efforts to

increase accountability and… and from HASA and therefore support Int. No. 935. We're also here respectfully requesting support from the City Council to help offset the decades and now it has been decades of cuts to HASA contracts and the dramatically the unforeseen cost associated with dramatically rising rent. In Brooklyn last year alone rent's went up an average of 10% and I'd love to see a show of hands of people in the room who got a 10% salary increase last year, very few of us did. What we need is we need 3 million dollars from City Council to keep the doors open of these programs that have been providing housing to formally homeless people living with AIDS. The Council has a long history of initiatives to fill in the gaps in funding to get us closer to the end of AIDS. The Council funded the New York City Community of Color HIV/AIDS initiative then the Injection Drug Users Help Alliance and this year because of the dramatic increase in homelessness, we need some support from the council to address homelessness among people with AIDS. And I can't sit here and not echo the comments from our individual members. HASA needs to make sure that all of their staff is trained in the new

approach that this administration is advancing when it comes to welfare. The new approach that… that believes that this is actually a safety net. Our members report miss information, rude behavior, lack of clarity from all levels of HASA workers and HASA just needs to do better and I know that HRA said you know give us the names, give us specific examples and we will start to compile those but it is widely you, if you go to any welfare center and ask any person walking in or out how they were treated, if they got full information, they will almost across the board tell you know or I was not told about that particular benefit, so there's something needs to happen there. We need better training at HASA, so I thank you again so much for your leadership.

CHAIR LEVIN: Just to follow up on that point, I agree that it's not really necessary just about a particular case worker at a particular time working for you know that's what were continuing to find, it's… it's more making sure that we have systematic accountability and standards across the board for HASA (inaudible).

JOSEPHINE PEREZ: Ok can you hear me.

CHAIR LEVIN: Yes.

JOSEPHINE PEREZ: Hello my name is Josephine Fantasia Perez, I am a transgender woman. I represent, I'm here to represent for Trans Justice on the Transgender Community Club of United States of America. Right, I'm an activist, a rallier, protester, I've been in a lot conferences. Some of you'll may know me, some of you'll may not. I'm just tired of the not enough being done for the transgender community. We need better services, more grants and funding's, more money for places to better service us transgender people all over the United States of America. Not just in New York City. You know we need legislative to work big and hard on transgender not being homeless in the street. Not having drug and alcohol addiction can a lot of transgender the reason why they go to drugs and alcohol addiction is because of lack of services and support. We need jobs, food, education, we need programs to be educated and trained and lack of knowledge and understanding. Also, I also suffer mental development disorder, mental disability and I also suffer mental so people with severe mental illness do count and the HIV book of all walks of life. Which is gay, lesbian, bi-sexual and

heterosexual to. A lot of HIV programs say they can't take you in because of you not suitable for the program or because they can't cater to your mental illness, bull shit. This is where the grants and funding, what are they doing with grants and funding and money when they get it. How are they providing it for transgender people right? So we need to find out and people need to go visit these programs and find out if there, if you'll give grants and bills pass a bill on us and give grants and funding for the HIV transgender community, it needs to be provided right and well you know and provided right you know like for services because I don't feel that we should have to suffer without housing right programs, no type of activities, trips for fun, no type of gatherings for one another. They cancelled support groups, transgender support groups because of lack of funding's and grants. It's not fair to us, we need to support one another as a transgender community cause some people can't understand our issues so we have a transgender women support group, transgender men support group for women and men that can't understand our issues that are having sex with gay, lesbian and bi-sexuals. Same thing with

transgender who are negative, if you look at the rate of transgender population throughout the United States of America that are HIV positive today, it's a huge and high rate. People may not think it exists but look of how many transgender get tested and become HIV positive. So people that are negative need to be provided services that are transgender to because they end up becoming HIV positive. We are not supposed to be targeted as prostitutes or targeted as drug and alcohol users, junkies, whatever. We need the proper services we need, school, jobs, education and proper HIV and mental health services throughout the United States of America. I stand for Trans Justice and I stand when our mean when I mean I stand for them. I live at 454 Lexington Avenue between Thompson and Truth Housing Works and they are a very great women transitional housing program. They have took transgender women into their program. They have advocated on my behalf with HASA to extend my stay. Nanete Laco (sic) and Barry Simmons (sic). They're a very great transitional housing program and some SROs I didn't feel comfortable in because the lack of roaches and rats and crap on the floor in the building smells and

all types and I'm sanitary as a person living healthy with HIV you know because some people are not able to take care of their own self with HIV. So we do not want to in end the world with AIDS and HIV, we want to prevent people from catching HIV and AIDS and we want to keep people from good viral low suppression undetectable so we can live a long a long time. I don't want legislative to think that they build TTHP transgender transitional housing program just so I can die, you know they need more TTHP programs. Transgender housing programs throughout the United States of America for all HIV programs and any other programs, mental health to.

CHAIR LEVIN: Thank you very much, Thank you Josephine. Council Member Johnson.

COUNCIL MEMBER JOHNSON: Josephine I want to thank you for being here, that's amazing testimony to give without any prepared remarks so your fantasize and it's great to have activist like you here who are out there in the community on the front line and I know that you being here today, your speaking on behalf of a lot of trans people that aren't able to be here. So I really appreciate that fact that you are so open and honest about your own

status and about your own struggles with addition and mental health issues, so thank you. You know as I think any Annie Soriano and other people have testified that HIV and AIDS the epidemic that continues to rage on in our city and nationally is really and epidemic fueled by poverty, addiction, mental health issues and homelessness and that's what I think you testified about today, that's what Vocal is all about and it's why we like working with all of you and I feel very excited and hopeful that in the next little while were going to have hopefully good news to announce on both of these bills, Council Levin and I, Chair Levin and I are working hard to see some of this through. So I want to thank the Chair for hearing these two bills today and I look forward to working with all of you that testified to make sure they become a reality. Thank you for your activism and your testimony today.

JOSEPHINE PEREZ: Thank you.

CHAIR LEVIN: Thank you Council Member Johnson, thank you very much to this panel for your thoughtful testimony and thank you to everybody that's here continuing to advocate and as I said before the next hearing on HASA that we want to have

is discussing the input, how the implementation of HASA for All is going, so hopefully will be there in a couple of months, so with that does any other person want to testify today? Seeing none this hearing is adjourned.

[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 October 29, 2015