
AIDS HOUSING IS HEALTH CARE: A PRIMER



An AIDS Housing Primer for:

- Elected Officials
- Community Planners
- Service Providers
- Consumers

By Stanley de Mello

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Table of Contents

About Connecticut AIDS Residence Coalition	1
From the Executive Director	2
Foreword	3
The Early Days of AIDS Housing in Connecticut	4
Current Inventory of AIDS Housing in Connecticut	6
Support Services: Case Management	8
Planning and Priority Setting: Federal, State and Local	9
Federal Housing Resources for Persons Living with HIV/AIDS	15
State Housing Resources for Persons Living with HIV/AIDS	19
Barriers to Housing Programs: Individual and Systemic	20
AIDS Today: Changing Needs, Changing Solutions	23
HIV/AIDS, Housing and Homelessness	25
Implications for Existing AIDS Housing Programs in Connecticut	27
Connecticut AIDS Residence Coalition Membership	29

Connecticut AIDS Residence Coalition

Vision Statement

All people living with HIV/AIDS will have appropriate housing and a full range of services necessary to live their lives in dignity.

Mission Statement

CARC, as a membership organization, seeks to identify and serve the housing and support needs of people living with HIV/AIDS by:

- Establishing and maintaining high standards of housing and support services;
- Providing technical assistance that builds organizational capacity;
- Advocating for responsible public policy;
- Generating community awareness.

From the Executive Director

“AIDS Housing is Health Care” has been one of the lasting mantras of the AIDS housing community throughout the country. Early on, those who provide supportive housing for persons living with HIV/AIDS learned an important lesson: without a safe and stable living environment, persons living with HIV/AIDS could not and did not receive appropriate health care. Without a place to call “home” the barriers to good health were insurmountable. AIDS was just one more burden to carry; medication adherence was unattainable; and actively managing one’s illness was beyond reach.

Unfortunately the barriers to safe, supportive and affordable housing are myriad. Some of these barriers are spelled out in this booklet. Perhaps the greatest challenge to those seeking appropriate AIDS supportive housing, whether consumers for themselves, providers for their clients, or policy makers for their constituents is the fragmented and confusing patchwork of “systems” presently available. One clear and comprehensive solution is not available. Differing bodies of federal and state government have attacked this monolithic problem from different angles, with differing philosophies and separate social service plans. Rarely do these systems interact together.

In this booklet, we have attempted to put in one place a brief outline of the issues pertaining to providing AIDS housing in Connecticut, a look at all the confusing federal and state systems, resources presently available in Connecticut for persons living with HIV/AIDS, and an inventory of the AIDS housing programs that are available through our member agencies.

As a coalition, we are comprised of all the agencies recognized and funded by the State of Connecticut Department of Social Service (DSS) to provide AIDS specific housing. As you can see from our Mission Statement on the opposite page, one of our commitments is to advocate for responsible public policy. It is our hope that by providing this overview to policy makers and their constituents, we may achieve that goal so that our vision statement becomes a reality, that “all people living with HIV/AIDS will have appropriate housing and a full range of services necessary to live their lives in dignity.

John

John Merz

Foreword

In order to effectuate responsible public policy and appropriate public funds elected officials today have the daunting task of trying to stay informed on all the issues that their constituents are faced with. The Governor, State Senators, State Representatives, Mayors, First Selectmen, Town Councilors, and our Congressional Delegation have to understand the issues and should have the most up to date information before they can support policy and budgetary initiatives. Community planners, service providers and consumers need this information to make the connections necessary to access the housing services needed by persons living with HIV/AIDS.

The purpose of this primer is to provide elected officials, consumers, planners, advocates and service providers information about the changing face of AIDS in Connecticut and the need to view AIDS housing as a **health care issue**. An overview of the planning process, the funding structure at both the federal and state level that supports AIDS housing, and a description of the *continuum of care*, including the role of emergency shelters, transitional living programs, and permanent supportive housing, will be presented.

The Early Days of AIDS Housing in Connecticut

In Connecticut, as in many communities across the country, AIDS housing programs were started in response to a clear crisis—people who were sick and dying had no place to live. People living with AIDS became homeless due to a dramatic loss of income associated with loss of work due to illness, or they lost their housing due to discrimination based on their HIV status and/or homophobia.

In October, 1987, under the leadership of Reverend Thad Bennett, then Executive Director of AIDS Ministries, five organizations came together to talk about how to address the growing problem of housing for people with AIDS. They created the CT AIDS Residence Coalition (CARC), a collaborative entity to assist programs in building on the best practices for delivering supportive housing to people with HIV/AIDS.

Founding Agencies

The founding members of CARC were Center City Churches (CCC), CT AIDS Residence Program (CARP), McKinney Foundation, Catherine Kennedy/Leeway and St. Luke's Community Services (SLCS). By 1989, Center City Churches had opened a scattered site apartment program, St. Luke's Community Services opened the McKinney Residence, CARP opened a residential program, and CARC itself became incorporated.

Many AIDS housing programs were started by grassroots community organizations or individuals with the best intent, but with limited knowledge of operating social service programs. Other supportive AIDS housing programs were developed by social service providers experienced in working with a homeless population, but new to the field of AIDS.

One of the first tasks the coalition and its founding members accomplished was the development of *Standards of Care* to which they would hold themselves accountable and offer to those interested in developing AIDS housing.

Standards of Care

The *Standards of Care*, is a document that delineates specific standards and describes the best practices of operating supportive residential programs for people living with HIV/AIDS. These standards are meant to be used as guidelines for program development and evaluation rather than to advocate for any particular model. The services attached to the housing models described in the standards

range from grassroots, home-based models of care to clinically based, goal oriented case management models that focus on substance abuse treatment. Most programs strive to balance the need for structure, and an environment that is both supportive and least restrictive to residents.

The *Standards* reflect three classifications of supportive housing that are consistent with the Continuum of Care: emergency housing, transitional housing, and permanent housing.

The *Standards of Care* is a tool to assure the quality of programs by setting down guidelines for services, health and safety, and general management. The overarching goal is to have a method of identifying programs' strengths and shortcomings, highlight their best practices and develop a framework, timeline and process for technical assistance to correct deficiencies.

The *Standards* attempts to reflect and address the complex issues that affect the quality of life for people living with HIV/AIDS. It provides best practices related to topics such as resident eligibility, screening potential residents, staffing, policies and procedures. The backbone of each residential program is *empowerment*, that is, creating opportunities for people to shape their own lives and to offer them choices.

The State of Connecticut Department of Social Services, the City of Hartford, and the City of New Haven, are administrators of federal Housing Opportunities for Persons with AIDS (HOPWA) funds. As a condition of funding, they have required all agencies that are recipients of HOPWA funds to incorporate the *Standards of Care* into their policies and procedures for operating their AIDS housing programs and advise them to become members of CARC.

First Models of AIDS Housing

Group residences, congregate living facilities, and hospices were the most prevalent models of AIDS housing in the early years of the pandemic. Most provided around-the-clock staff and a more intensive structure of support and services for men and women who were ill and dying from AIDS at a much faster rate than is currently being experienced. Programs based on these models continue today.

The programming at these facilities was designed for people who are homeless or at risk of homelessness, have symptomatic HIV disease or AIDS and may have a history of substance abuse. In addition to HIV, other problems may include:

- ◆ Diminished physical capacity to manage their activities of daily living
- ◆ Manageable mental illness, cognitive impairments, or AIDS-related dementia
- ◆ Recent substance abuse problem with a commitment to recovery

Current Inventory of AIDS Housing in Connecticut

Since the Connecticut AIDS Residence Coalition (CARC) opened in January 1990, there has been the development, start up, and expansion of 26 AIDS residential programs. CARC has provided technical assistance and advocacy for all of these nonprofit agencies. All of these programs have some level of support services attached to them. The housing available includes:

- ◆ 13 congregate/group living facilities scattered throughout the state.
- ◆ 230+ scattered site apartments (many of these accommodate families)
- ◆ 188 spaces in group residences including Leeway a 30-bed, licensed skilled nursing facility dedicated to PWAs
- ◆ All of the AIDS housing programs in the state are members of CARC.

Hartford County

Center City Churches/Peter's Retreat	Group residence for 28 men/women 5 units scattered site program
Christian Activities Council/Zezzo House	16 one-two bedroom units in 3 buildings
Chrysalis Center	22 unit supportive housing project plus Scattered site program
Human Resource Agency of New Britain	19 units of scattered site housing
Immaculate Conception Shelter	60 bed shelter for men
CRT/McKinney Shelter	90 bed shelter for men; day respite
Mercy Shelter & Housing/Project Mercy	44 units of scattered site; 9 bed group residence; 9 unit "step down"
St. Philip House	8 one-bedroom units congregated 3 units of scattered site housing
Tabor House I	6 bed residence for men; 1 respite bed
Tabor House II	6 bed transitional living for women

Windham County

Perception Programs/Omega House	10 bed group residence for men and women in recovery
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New London County

Alliance for Living 17 units of scattered site housing

New Haven County

CT AIDS Residence Program (CARP, Inc.) 7 bed group residence
30 bed scattered site housing
17 bed transitional living program

Independence Northwest 8 units of scattered site housing

Leeway 30 bed skilled nursing facility for PWAs

New Haven Home Recovery 8 unit apartment building for women
37 units of scattered site housing
Homeless shelter for women & children

New Opportunities for Waterbury 7 unit scattered site program
8 unit transitional housing program

Fairfield County

AIDS Project Greater Danbury 6 bed group residence
Scattered site housing

Alpha Home 3 units of transitional housing for families

Bread & Roses 8 bed guesthouse for men & women

Catholic Family Services of Bridgeport 13 units of scattered site housing

Family Services Woodfield Supportive Services to PWAs

Helping Hand Center 10 bed group residence for Latino men in
Recovery; 10 unit scattered site housing

Stewart B. McKinney Foundation 2 family units

Prospect House 32 bed shelter for single adults
6 SRO units for single adults
8 bed transitional living program for men
who are multiply-diagnosed

St. Luke's Lifeworks 9 bed supportive group residence

Support Services: Case Management

A key resource of AIDS residential programs is the case manager that oversees the planning and delivery of services for each individual or family. The case manager works with residents to determine their needs and works with agencies to assure that services are available and appropriate services are accessed for each resident. A case manager does crisis intervention, is a liaison to health care and community agencies, may facilitate weekly house meetings, maintains residents' records and care plans, addresses problems with residents as they arise, and accompanies residents to appointments. Currently, case managers in housing programs are limited to serving no more than eight client's households. That standard is being reviewed in light of the changing profile of clients who are healthier and living longer as a result of new medications and therapies.

Care Coordination includes the following:

- ◆ Doing individual assessments and needs assessments, which may include school registration, obtaining documents such as birth certificates and Social Security cards, and determining a resident's eligibility for financial assistance.
- ◆ Writing plans for services, treatment and goals that cover the range of financial, personal and housing objectives.
- ◆ Linking people living with HIV/AIDS with services and doing the necessary referrals.
- ◆ Doing advocacy work to obtain services for residents, and then implementing, monitoring and coordinating those services.
- ◆ Serving as liaisons between clients and landlords in scattered site programs.
- ◆ Performing regular and periodic evaluations and reviews of plans.
- ◆ Documenting activities.
- ◆ Maintaining the confidentiality of all information.

Planning and Priority Setting: Federal, State and Local

Planning for the Use of Federal Funds

There are different planning processes that determine the needs and priorities for spending federal housing and support services dollars, and healthcare dollars for persons living with HIV/AIDS that flow to Connecticut from the U.S. Department of Housing & Urban Development (HUD) and the Health Resources & Services Administration (HRSA) division of the U.S. Department of Health & Human Services.

HUD funds programs such as HOME, CDBG, ESG, Section 108, and Housing Opportunities for Persons with AIDS (HOPWA), that are subject to the local or state community development plan that is also known as the Consolidated Plan (Conplan). Other HUD funds targeted to assist the homeless are subject to Continuum of Care planning (CoC), that identifies current services and gaps in services and sets funding priorities.

HRSA funds are authorized by the Ryan White CARE Act. Primarily a healthcare funder, HRSA allows Ryan White funds to be used for emergency housing, short term assistance, or one-time assistance requests that enable an HIV infected individual to access or maintain their housing in order to receive healthcare. Every year a Ryan White Emerging Needs Assessment and a Priority Setting process are conducted under the auspices of each area Ryan White Planning Council. The State Department of Public Health, the City of Hartford, and the City of New Haven, as administrators of federal Ryan White CARE Act funds, are responsible for initiating the statewide, and local Emerging Needs Assessment.

Since 1999, HUD and HRSA have placed a lot more emphasis on the importance of collaboration between local HOPWA Administrators and Ryan White Planning Councils. Working together in their planning and priority setting processes, they are being challenged to use their funds more efficiently and effectively. The long-term goal of this collaboration is to limit the use of HOPWA funds for support services to 35% of funds allocated so that more of the funds are available for actual housing costs. At the same time less Ryan White funds would be used for emergency, short-term housing so that more of those funds would be available to provide support services related to healthcare.

Consolidated Planning (Conplan)

HOPWA funds are subject to the consolidated planning process. Each of the 13+ entitlement communities (population of 50,000 +) is required to undertake a comprehen-

sive community development planning process that involves as many stakeholders as possible. The Conplan process is collaborative and inclusive and the plan is comprehensive and integrated with housing and economic development initiatives. The end result of this process is a 5-Year Con Plan that requires an annual review and update of action steps to meet the stated goals and objectives.

Most communities in Connecticut begin the annual Conplan action step update process during the fall season, convene several work groups that will meet several times before a draft plan is developed. The process ends with public hearings to solicit citizen feedback on the draft plan and a resolution from the town council or board of selectmen. The funding streams that are subject to the Conplan includes:

- ◆ Community Development Block Grants (CDBG)
- ◆ Housing Investment Partnerships (HOME)
- ◆ Emergency Shelter Grant (ESG)
- ◆ Housing Opportunities for Persons with AIDS (HOPWA)

Continuum of Care Planning (CoC)

Since many HIV infected persons are homeless, their housing needs are also identified and prioritized in the continuum of care planning process. This community-based process provides a comprehensive **response to the different needs of homeless individuals and families**. The outcome is a comprehensive and coordinated housing and service delivery system called a Continuum of Care that provides a balance of:

- ◆ Emergency housing
- ◆ Transitional housing
- ◆ Permanent housing
- ◆ Services

Subpopulations served by the CoC include:

- ◆ Veterans
- ◆ Seriously Mentally Ill
- ◆ Substance Abuse
- ◆ HIV/AIDS
- ◆ Domestic Violence
- ◆ Youth

The CoC process may or may not be undertaken in a community. It is only required if there are groups of providers concerned about homelessness that intend to apply for funding streams that are part of HUD's Annual SuperNOFA. The schedule and length of time of the continuum of care process differs from community to community.

Some of the larger urban areas like Hartford, New Haven, Bridgeport, Norwalk, Stamford, Danbury have incorporated the Continuum of Care plan into the larger Consolidated Plan to make it more comprehensive. These same communities have formalized the CoC by establishing steering committees that meet year-round to enhance collaboration and gather data for their applications.

The SuperNOFA is usually announced in February. Its funding programs include:

- ◆ Supportive Housing Program (SHP)
- ◆ Shelter Plus Care (S+C)
- ◆ Section 8 Moderate Rehabilitation for Single Room Occupancy Dwellings (SRO) Program

Ryan White Needs Assessment Survey

The Ryan White Statewide HIV Care Consortium, the Title I Planning Council of New Haven and Fairfield County, and the Title I Planning Council of Greater Hartford co-sponsor an annual Needs Assessment Survey of health care providers and consumers. The results of this survey is then used as the basis for setting priorities for services in each of the eligible metropolitan areas during the next funding cycle.

Although Ryan White Funds are to be used for healthcare services, HRSA recognizes that without shelter, a person infected with HIV/AIDS would not be able to receive adequate healthcare or be able to adhere to the strict regimen of new medications. Therefore, they have allowed housing assistance to become an eligible activity for their funding. Housing assistance requests need to be linked to healthcare access and provision and can only be short term, emergency benefit.

Planning for Use of State Funds

The State of Connecticut does not have a formal planning process although the Department of Economic and Community Development (DECD) serves as the lead agency among state agencies in housing planning. Together with DSS, which oversees and funds AIDS housing programs, DECD has adopted the federally required Consolidated Planning process to identify needs, develop strategies, set priorities, and create action steps over the five-year planning cycle. Historically, DSS has supported the statewide goals and objectives of CARC's AIDS Supportive Housing plan and has endorsed their inclusion in the State Conplan that covers all communities of less than 50,000 people.

Partnership for Strong Communities

In 1998 several advocacy groups including CARC, the CT Coalition to End Home-

lessness, the National Alliance for the Mentally Ill, the Corporation for Supportive Housing, and the CT Housing Coalition decided to join forces and form the Partnership for Strong Communities. Their efforts are aimed to assure that all people have the housing and support services to live in dignity. They developed an agenda to advocate for more housing resources from the Governor and State Legislature during the annual legislative budgeting session. Their long-term agenda was multi-pronged and included:

- ◆ Housing Trust Fund - to finance affordable housing projects statewide.
- ◆ Housing Plus - a new rent subsidy/support services initiative.
- ◆ PILOTS - an initiative to address the supportive housing needs of people with mental illness and addictions. State funds for support services will be matched by federal/private funds to finance or subsidize rental units.
- ◆ Housing Tax Credits - a tax credit program for corporations that contribute to affordable housing.

The Blue Ribbon Commission to Study Affordable Housing

The Commission, whose members are appointed by the Governor and Legislative leaders, took on the task of studying the need for affordable housing in the State and made numerous recommendations that were incorporated into the agenda of the Partnership for Strong Communities.

The Connecticut AIDS Residence Coalition AIDS Supportive Housing Plans

The CT AIDS Residence Coalition (CARC) is a statewide membership organization of 26 agencies that provide housing and support services to people living with HIV/AIDS in Connecticut. CARC has been in existence for ten years and has provided leadership in planning and development of quality supportive housing for people with HIV/AIDS.

It has commissioned two AIDS supportive housing plans during the past four years. In 1996, CARC published the "Blueprint for the Future" and in 1999 it issued "Changing Needs, Changing Solutions: An Assessment of Supportive Housing for people with HIV/AIDS." The plan provides a framework to assist CARC and its member agencies in identifying its priorities for the next three-five years. CARC has disseminated this planning document to its member agencies so that they can include the recommendations in their local Conplan.

The methodology included securing primary data through:

- ◆ Face-to-face consumer interviews
- ◆ Consumer and provider focus groups
- ◆ Interviews with CT providers of supportive housing

- ◆ HUD Consolidated Plans
- ◆ AIDS Supportive Housing Needs Assessments from other States
- ◆ National and CT based epidemiological research
- ◆ A review of key housing subsidy programs in CT
- ◆ Telephone interviews with key policy makers

The recommendations that came out of this planning process were incorporated into the State's new five-year Consolidated Plan, as well as Hartford's Consolidated Plan:

- ◆ New supportive housing projects should be focused on scattered site housing with linkages to community based social, vocational, and economic support systems. They should include new housing development, rental subsidies, and other forms of economic support.
- ◆ The continuum of supportive housing for persons living with HIV/AIDS should be developed within the framework affordable housing.
- ◆ Consumer advisory committees need to be created within CARC member agencies so that new supportive housing models are responsive to consumer needs and priorities, i.e. harm reduction models to address needs of persons with substance addictions.
- ◆ CARC members and consumers need to be active participants in the federal, state, and local planning process, not only to establish needs and prioritize projects, but also to ensure that supportive housing is included within the overall community development plans.
- ◆ CARC members and consumers need to be organized and active in fostering public policy.
- ◆ All AIDS residences need to subscribe and support program evaluation that includes data collection, performance measures for both client and system outcomes, and dissemination of results for the purpose of promoting best practices and formulating responsible public policy.
- ◆ Consumers need regular updates & notification about the availability of housing within CARC and in the broader community.

Local Planning

There are other local and regional planning processes. Advocates for people living with AIDS or other disabilities need to know about them and be involved with them. The risk is that the priorities and desired outcomes of these plans may be at odds

with or do not include those developed in the Continuum of Care and the HOPWA planning process.

These plans cover:

- ◆ Mayor's task force on AIDS
- ◆ Neighborhood revitalization
- ◆ Economic development
- ◆ Workforce development
- ◆ Transportation

Neighborhood Revitalization Zone Planning

In 1995 the Connecticut Legislature passed legislation that created the Neighborhood Revitalization Act. This act is an attempt to address the growing problem of abandoned and foreclosed properties in our urban communities that threatened the viability of the housing stock. The legislation allows neighborhoods to form revitalization committees to develop strategies and a plan of action to maintain the existing housing stock. The local governing body i.e. town council or board of selectman must then sanction the committee's recommendations in order to make them eligible for state funding and support.

It is important for advocates of AIDS supportive housing to be knowledgeable about this legislation and the process that establishes housing priorities in local neighborhoods especially if they want to develop AIDS housing there. Obtaining local support for a housing project can be a difficult process and has often led to delays or the demise of a proposed project.

Plan of Development

Every one of the 169 cities or towns in Connecticut has a "***Plan of Development***" that sets forth the priorities for land use development in the community. This plan is updated every ten years. Again, advocates for AIDS housing need to be aware that such a plan exists, try to become involved in the process and review the plan prior to seeking local support for a housing project. In the event that elements of the plan are identified as "barriers to fair housing," a complaint can be filed with HUD that results in a "analysis of impediments" process. This process requires the community to review and prove that their requirements or restrictions are not discriminatory.

Federal – both the Department of Housing and Urban Development (HUD) and the Health Resources and Services Administration (HRSA) provide funds for housing and support services that benefit people living with HIV/AIDS. HUD funding through the Housing Opportunities for Persons living with AIDS program is primary while HRSA funding through the Ryan White CARE Act is a funding of last resort.

Federal Housing Resources for Persons Living with HIV/AIDS

U.S. Department of Housing & Urban Development Funding (HUD)

Housing Opportunities for People with AIDS (HOPWA)

HOPWA is HUD's only program dedicated to meeting the housing needs of people living with HIV/AIDS. This funding stream is divided into two categories 1) HOPWA Formula Funding and 2) HOPWA Competitive Grants for Special Projects of National Significance.

Limitations of HOPWA – It is important to note that HOPWA is only able to satisfy 20% of the need for housing. The National AIDS Housing Coalition and local AIDS housing groups have advocated for increased HOPWA funding.

HOPWA Formula Funding

Ninety percent of total HOPWA dollars are distributed by using a formula. The formula is based on the number of new AIDS cases reported to the CDC; awarded on an annual basis to States or eligible metropolitan areas (EMA) that report an incidence of AIDS that exceeds the minimum threshold of 1,500 cases. Those EMA's that exceed the national incidence rate receive 25% additional funding. This is decided yearly. On the downside, the fluidity and fluctuation of newly reported AIDS cases greatly affects funding and planning possibilities.

Eligible activities for HOPWA funding

HOPWA funds may be used to assist all forms of housing designed to prevent homelessness:

- ◆ Housing information services including counseling, information, referral services, and fair housing counseling.
- ◆ Resource Identification to establish, coordinate and develop housing assistance resources.
- ◆ Acquisitions, rehabilitation, conversion, leases, and repair facilities to provide housing and services.
- ◆ New construction for SRO dwellings and community residences only.
- ◆ Project- or tenant-based rental assistance, including assistance for shared housing arrangements.
- ◆ Short-term rent, mortgage, and utility payments to prevent homelessness.

- ◆ Supportive Services including health, mental health, assessment, permanent housing placement, drug and alcohol abuse treatment and counseling, day care, personal assistance, nutritional services, intensive care, and assistance in gaining access to local, State, and Federal government benefits and services.
- ◆ Operating costs for housing programs including maintenance, security, operation, insurance, utilities, furnishings, equipment, supplies, and other incidental costs.
- ◆ Technical Assistance in establishing and operating a community residence, including planning and other pre-development or pre-construction expenses and including outreach and educational activities.
- ◆ Administrative expenses – grantees limited to 3% of grant and project sponsors limited to 7% of grant.

HOPWA Competitive Grant for Special Projects of National Significance

Ten percent of HOPWA dollars are distributed through an annual competition called “Special Projects of National Significance” that allows, state and local units of government, and nonprofit community based organizations to submit proposals for housing and support services that are innovative and replicable. Grantees are awarded up to \$1 million dollars that is to be spent over a three-year grant period.

Other HUD Supportive Housing/Community Development Programs

While not exclusively for persons living with HIV/AIDS, there are other HUD funding streams that fall under the umbrella of the Stewart McKinney Homeless Assistance Act, or Community Development that can be applied for:

- ◆ **Shelter Plus Care (S+C)** - provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program.
- ◆ **Supportive Housing Program (SHP)** – designed to develop supportive housing and services that will allow homeless persons to live as independently as possible.
- ◆ **Section 8 Moderate Rehabilitation for Single Room Occupancy Dwellings (SRO) Program** – provides rental assistance on behalf of homeless individuals in connection with moderate rehabilitation of SRO dwellings. Resources outside the program pay for the rehabilitation; however, rental assistance covers operating expenses of the SRO housing. Public Housing Authorities and private nonprofit organizations that subcontract with PHAs are only eligible applicants.

- ◆ **Section 8 Vouchers for Persons with Disabilities in the Mainstream** - A number of PHAs, including the State DSS, the cities of Hartford, New Britain, Waterbury, New London, Torrington, and Danbury have responded to the HUD NOFA for this particular funding stream. The process is highly competitive and the numbers of vouchers are limited. This funding stream has a lot of potential, but it requires a high level of collaboration between service providers that serve different populations and the local housing authority. Thus a collaborative effort has a much greater chance of success. One obstacle to newly diagnosed PWAs is that those who are on the waiting list are given first opportunity to access these vouchers. It means that they will have a long wait before their name reaches the top of the list.

- ◆ **Supportive Housing** - The Corporation for Supportive Housing (CSH) is a national financial and technical assistance intermediary dedicated to helping nonprofit organizations develop and operate service-enriched permanent housing for individuals and families who are homeless or at risk of homelessness and who have special needs such as mental illness, HIV/AIDS, and/or substance abuse histories. In Connecticut, CSH has sponsored nine supportive housing demonstration sites. The outcome was 281 units of supportive housing – permanent, affordable apartments combined with services and supports for tenants. These housing units are located in Bridgeport, Hartford, Middletown, New Haven, Stamford, Torrington, and Willimantic.

An interim evaluation has revealed the cost-effectiveness of these CSH projects: **The per diem State cost of housing** - (\$19) is significantly less than the cost to the State of inpatient psychiatric care (\$660), nursing home care (\$207), residential substance abuse programs (\$100), and incarceration (\$70). **The annual cost of the housing** from all sources is \$12,975 per tenant. (about \$35 per person per day) The State's share is \$7,002 or 54%.

- ◆ **Community Development Block Grant** – to develop viable urban communities by providing decent housing and a suitable living environment and expanding economic opportunities, principally for persons of low and moderate income, to benefit very low, low, and moderate-income persons, eliminate slums and blight, and address urgent community needs. Cities with populations of at least 50,000 and urban counties of at least 200,000 (excluding the population of entitled cities) are eligible to receive annual grants. HUD uses a statutory dual formula to determine amount of each entitlement grant. Only 13 communities in Connecticut are allocated CDBG funds by HUD.

- ◆ **HOME Program** – used to expand the supply of decent and affordable housing for low and very low-income persons; includes existing rental housing made affordable through tenant based assistance. Strengthens the abilities of state and local governments and nonprofit organizations to design and implement strategies for providing decent, affordable housing. Provides financial and

technical assistance to participating jurisdictions, including the development of model programs. Creates and strengthens partnerships among all levels of government and the private sector.

- ◆ **Section 8 Voucher Program** - Public housing authorities are usually the only eligible entities that can apply to HUD for new Section 8 vouchers. Unless they create a local preference for persons living with HIV/AIDS priority is given to people on the waiting list. Most urban communities with the highest incidence of AIDS have a very long waiting list that is likely to be closed. The list remains closed to new applicants until it is purged. It means that those PWAs currently on the waiting list and those that have been newly diagnosed and would be eligible based on their income will not be served anytime soon.

Health Resources and Services Administration Funding (HRSA)

Ryan White Care Act

Through the Health Services and Resources Administration (HRSA) two funds are available for Connecticut residents to pay for short-term emergency housing. Eligible applicants must have an HIV/AIDS diagnosis and their rent needs to be greater than 50% of their income but less than 80% of income. Their requests for housing assistance need to be related to access or maintenance of their healthcare. Only case managers can submit applications for their clients. Both funds are administered by CARC.

Greater Hartford EMA Ryan White Title I Housing Assistance Fund

Pays for first month's rent, arrearage, and short-term rental assistance. Maximum amount per year is \$1,800 per person. Current Annual Budget: \$237,500.

Statewide Consortia Ryan White Title II & New Haven/Fairfield County Ryan White Title I Emergency Housing Fund

Pays for first month's rent and arrearage only. Maximum amount of assistance per year is \$800 in New Haven, New London, and Windham Counties. Fairfield County has a cap of \$1,000 per year per person. Current Annual Budget: \$170,000.

State Housing Resources for Persons Living with HIV/AIDS

Residences for Persons with AIDS (DSS)

These funds, subject to annual appropriations by the state legislature, are used to support the operational costs of all the AIDS Residential Programs. DSS advises agencies to become a CARC member and requires that their housing and support services be in compliance with the CARC *Standards of Care* prior to approval of funding.

AIDS Bond Fund (DSS)

This dedicated fund can be used to finance acquisition, development, and capital improvements for AIDS housing. DSS requires applicants to become CARC members and comply with the *Standards of Care* prior to approval of funding.

Barriers to Housing Programs: Individual & Systemic

There are individual and systemic barriers or impediments to housing persons living with HIV/AIDS.

At the individual level it includes:

- ◆ Lack of adequate income
- ◆ Poor or no credit history
- ◆ Criminal history, especially felony convictions
- ◆ Undocumented immigrant status
- ◆ Burned bridges with other systems
- ◆ Lack of independent living skills
- ◆ Housing discrimination
- ◆ Family status or size

The housing workgroup of the statewide Ryan White HIV Care Consortium consisting of consumers, providers, and funders has identified several systemic barriers that prevent homeless, low-income persons with HIV/AIDS from accessing or maintaining their housing. It includes:

- ◆ Housing market in Connecticut – a lack of affordable housing in the state
- ◆ Fair Market Rent in Fairfield County very high
- ◆ Federal definitions/formulas/regulations for funding AIDS programs are inconsistent, thus creating a barrier to delivery of coordinated and integrated services
- ◆ Local Public Housing Authority tenant selection criteria is prohibitively strict and does not sufficiently consider efforts made by consumers to improve their situations , or consider mitigating circumstances presented by applicants
- ◆ Federal Shelter Plus Care programs that have reached their 5 year limit may not receive additional appropriations

Public Housing Authority (PHA) Administrative Plan

AIDS housing advocates have tried for years to engage and gain the support of local PHAs since they are often the only eligible entities that can respond to HUD NOFAs but it has been an uphill struggle. This is for several reasons outlined below.

Urban PHA Re-Inventing Themselves

Many of the larger, urban-based PHAs are re-inventing themselves in order to survive. Federal cuts in operating subsidies and modernization funds have forced them to re-define who they will serve. Instead of serving the extremely low and low-income population, they are now serving households with moderate incomes. They have also embraced the welfare-to-work policy that the federal and state governments have enacted. It is reflected in their twin goals to:

- ◆ Support families in their quest for economic self-sufficiency and home ownership.
- ◆ Redevelop or rebuild each public housing project to achieve lower densities and modern housing quality standards.

PHAs are reducing the quantity and density of their public housing communities and are replacing them with single-family houses for public housing tenants that qualify to become first-time homeowners. At the same time, new rental units are designed for families that want to rent with the option to buy.

Public housing tenants who have been displaced because their units were demolished have been issued Section 8 vouchers so that they can find apartments in the marketplace. While many individuals and families have been successful in finding new housing, others have not fared as well.

Zero Tolerance Drug Policy, Criminal History, and History of Evictions

As a matter of policy and practice, PHAs will screen out and disqualify applicants who have a recent history of drug addiction, criminal convictions, or prior evictions. These policies have become a substantial impediment to finding housing for many persons living with HIV/AIDS that have such a background.

PHAs have implemented very strict guidelines and regulations concerning drug use and other criminal behavior at their properties that disqualify many of the clients of the HOPWA/Ryan White Programs. In addition, there are long waiting lists that are most often closed. When they do open up, the time frame is very short and new applicants are selected by lottery.

Local Preferences

Although they have the authority to create local preferences, most refrain from doing so for fear of having to defend a preference for any one particular group of people.

PHA and Local Continuum of Care Partnership

A recent change in federal regulations requires local public housing authorities to participate in consolidated planning. It encourages them to collaborate with community based agencies and has resulted in a promising partnership model between the local PHA and the local Continuum of Care Committee that represents diverse groups of residents with special needs. Hartford, New London, and New Britain are a few communities where PHAs have partnered with Continuum of Care committees to submit joint applications for specific HUD funding programs.

Market Rate Housing

High Cost of Housing Is A Barrier

“Out of Reach” the September 1999 report prepared by the National Low Income Housing Coalition, concludes that for many households, full-time work does not provide enough income to afford a typical apartment. The study is based on federal “fair market rent” data and employs the generally accepted standard for housing affordability – that a household pays no more than 30% of its income for housing costs. Among the reports findings:

- ◆ Thirty-five percent of renters in Connecticut cannot afford a moderate one-bedroom apartment, and 43% cannot afford a typical two-bedroom unit.
- ◆ The study finds severe housing cost problems across the state, ranking Connecticut the eighth most expensive state in the country.

Implications for Persons Living with HIV/AIDS

Many PLWAs subsist on entitlements such as SSDI and SSI, which average out, to a monthly income of \$747. Others, who are working part-time (20 hrs) at the minimum wage of \$5.65 per hour earn \$490 per month. Still others, who receive State Administered General Assistance (SAGA) average \$350 per month in income.

It is readily evident that without rental assistance, persons living with HIV/AIDS are at severe risk of becoming homeless. It underscores the importance of advocating for increases in HUD funding for Section 8 Vouchers, HOPWA, and other supportive housing programs. It also reaffirms the need for AIDS advocacy organizations to partner with non-profit developers that are attempting to increase the inventory of affordable housing throughout the State.

AIDS Today: Changing Needs, Changing Solutions

The Changing Face of AIDS

Contrary to public opinion, the AIDS crisis is not over – not by a long shot. While newly reported cases of AIDS are down (total number of new AIDS cases fell 18% in 1997 and 11% in 1998), the number of people becoming infected with HIV continues to rise. The CDC estimates that the rate of new HIV infections is 40,000 per year. Over the years, the face of AIDS has changed. Heterosexual women of color, particularly African Americans, gay men, and youth represent a disproportionate number of newly infected persons. It is estimated that at least half of all new HIV infections in the U.S. are among people under 25.

The proportion of all AIDS cases reported among adult and adolescent women has more than tripled, from 7% in 1985 to 23% in 1998. Two-thirds (62%) of all women reported with AIDS in 1998 were African American. Additionally, in 1998 intravenous drug use (IDU) accounted for over 59% of all AIDS cases among women. African American children accounted for two-thirds (68%) of all reported AIDS cases in 1998.

The number of deaths has decreased overall (42% in 1997 and 20% in 1998), but has increased among people of color. In the 1980's African Americans accounted for 25% of new AIDS cases and Latinos for 14%. In 1998 the percentage of African Americans that accounted for new AIDS cases had reached 45% and Latinos 22%. Death rates in 1998 were 10 times higher among African Americans than Caucasians and 3 times higher for Latinos. In 1998, African Americans represented only 13% of the U.S. population, but accounted for 49% of AIDS deaths.

The Multiply-Diagnosed Individual

There are many issues and challenges that face service providers who want to house persons that are multiply-diagnosed with HIV/AIDS, mental illness, and substance abuse.

Multiply-diagnosed individuals who are homeless are difficult to engage and to maintain in housing and services. The uniqueness and sheer multiplicity of their needs make them unwelcome in many housing programs and impossible to manage appropriately in others. Unfortunately, the most costly populations to serve are the least socially acceptable.

The service delivery network is not set-up to serve this population. Staff must be cross-trained in multiple issues that impact consumers. It requires extensive coordination

and cooperation amongst agencies to deliver services. The lack of operating funds is a factor that creates instability in programs and leads to difficulty in finding and retaining experienced staff. Additionally, accessibility of detox and mental health services are systemic problems that need to be addressed by state and local government.

The Impact of New Medications and Treatments

Due to advances in HIV/AIDS treatments, however, people with AIDS are living longer. New medications have brought hope into the lives of many with HIV, but the highly complex regimens required for the drugs to be effective can only be properly followed within the structure of an adequate home. Many physicians won't even prescribe the life saving medications to homeless individuals because inconsistent use, lack of fresh water, refrigeration, nutrition, and a manageable schedule result in more virulent, drug-resistant strains of HIV being transmitted through the general population. One result of homelessness is that future generations may carry and transmit a "super virus" immune to all available drugs. Indeed, it is already happening.

Homelessness Is a Healthcare Issue

Homelessness is both a healthcare and prevention issue. Those with secure homes are less likely to engage in the behaviors that spread HIV. Those with homes can be targeted not just with prevention programs, but with substance abuse treatment, mental health care and job training programs. Furthermore, housing for people with AIDS correlates with increased access to the health care system and a greater likelihood of remaining in care.

Providing housing for people living with HIV/AIDS is a relatively inexpensive investment. A month of comprehensive supportive housing costs less than three days in the hospital – and homeless people wind up in hospitals simply for lack of a home in which to rest, recuperate, eat properly and take their medicine.

HIV/AIDS, Housing and Homelessness

compiled by Shawn Lang

Here are some facts that elected officials, policy makers, funders, and service providers should consider as they work together to develop effective strategies and successful outcomes:

- Nationally, 65% of people with HIV/AIDS cite stable housing as their greatest need next to healthcare. (National AIDS Housing Coalition)
- Rental Housing is out of reach for many of Connecticut's Working Families:
- Housing that is affordable costs about a 33% of a household's monthly income. An estimated 68,000 households in Connecticut pay more than 33% of their income for housing.
- "Out of Reach," a report prepared by the National Low-Income Housing Coalition, concludes that for many families, full-time work does not provide enough income to afford a typical apartment. The study found that 42% of renters in Connecticut cannot afford a moderate two-bedroom apartment.
- A family with one wage earner working full-time would have to earn at least \$15.67 per hour, or work 102 hours per week at minimum wage, to afford a two-bedroom apartment.
- Homelessness persists in Connecticut - between October 1998 and September 1999, 1,635 Connecticut families with over 3,151 children used emergency shelters last year; it is estimated that 15% - 20% of people who are homeless are HIV infected; between 33% - 50% of all people with AIDS are either currently homeless or in imminent danger of becoming homeless (Department of Social Services Survey of Shelters and National Commission on AIDS).
- There are not enough rental subsidies to meet the need in Connecticut.
- Waiting lists for housing subsidy programs at local Housing Authorities virtually throughout Connecticut are closed. Once on a waiting list, families must wait at least 2 years and sometimes up to 5 years before receiving a subsidy.
- Housing subsidies will allow persons living with HIV/AIDS to return to work part-time without jeopardizing their ability to pay for housing.
- Due to improvements in drug therapies and medical care, the number of deaths due to AIDS has decreased. Consequently, the number of people living with HIV/

AIDS has increased, as has the demand for housing. Since 1996, the majority of new HIV infections are in communities of color, which are already disproportionately affected by the lack of stable, affordable housing. (National AIDS Housing Coalition)

- In 1999, 81% of people with HIV/AIDS requesting housing from AIDS housing programs in CT were denied primarily due to a lack of space. (CARC statistics)
- There are long-term solutions to homelessness that work - A recently released study of Connecticut's seven-year Supportive Housing demonstration program shows that tenants who are provided with ongoing supportive services get jobs, use fewer state-funded services, and lead more stable lives. (Partnership for Strong Communities)
- A person living with AIDS receiving the maximum S.S.I. benefit of \$747 would pay over 82% of their income to pay the fair market rent of \$615 for a one-bedroom apartment in Connecticut.
- Recent changes in AIDS Housing Continuum (AIDS Housing Wash. – National Technical Assistance Project)

Previous	Current
Hospice and end-term care were the cornerstones of the system	High-end care needed only intermittently
Shared housing models/congregate living	Priority for ongoing housing assistance
Focus on housing development – there was very little rental assistance	Permanent housing with on-site services
	Focus on housing operations
Units turned over within two years due to deaths	Widespread use of rental assistance

- During 1999, CARC members provided housing and support to 1,037 men, women and children. This figure includes 251 family members. The demographic breakdowns by age and race are: less than 17 years old, 274; 18 – 30, 90; 31-50 years old, 609; over 51, 64. African/Americans, 411; Latinos/as, 381; White, 225; Native American, 1; Other, 19.

Implications for Existing AIDS Housing Programs in Connecticut

In the short-term, existing congregate living facilities will need to continue housing persons living with HIV/AIDS. There are just not enough affordable housing units that provide choice. At the same time, dedicated AIDS housing units are turning over more slowly. Since HOPWA funds can only meet 20% of the housing needs of PWAs, there is an increasing demand for rental assistance available in mainstream housing programs that will allow people more choice in finding housing.

There are two distinct groups within the AIDS community that need HIV/AIDS housing. The first group consists of those who are well and are focusing on employment retraining. Eventually they will have to be moved off subsidies, but re-accessing services when needed is a big issue for them.

The second group are those who are sick and failing on the new medications. Included in this group are those that have mental illness, substance abuse histories, and who may be undocumented aliens. Most of these people are poor and have incomes of less than 20% of median. They are families with children and those who are at risk of homelessness due to lost income and/or spent down their savings, and living in overcrowded conditions. Their uncertain future requires the maintenance of programs that are service enriched but not fully utilized.

Notes...Notes...Notes...Notes...Notes

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(continued)

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