

**HOUSING REFERRAL HANDBOOK\***

**NYNYIII HOUSING APPLICATION AND REFERRAL PROCEDURE**

**A GUIDE DEVELOPED BY AND FOR THE BRONX HEALTH AND HOUSING CONSORTIUM**

**AUGUST 2012**

*\*Please note that this document may be updated on an ongoing basis. Please check all information as contacts, regulations, etc may change over time*

## **INTRODUCTION**

The Bronx Health and Housing Consortium convened its first formal meeting on January 27, 2012 for the purpose of establishing a collaborative network of health, housing and social service providers in the Bronx with the shared goal of streamlining client access to health care and quality housing. The general goals of the Bronx Health and Housing Consortium are to:

- Provide a forum to coordinate housing support services with medical, mental health, substance abuse, and other social services in the Bronx;
- Develop linkages between primary care and specialty care as well as health focused outreach for chronically homeless individuals;
- Disseminate knowledge about housing issues, including opportunities and programs, to agencies and providers that typically do not have the expertise to access these services;
- Conduct a needs assessment for housing and related services in the Bronx, and bring diverse providers together to jointly advocate for these resources for individuals who are chronically homeless and engaged in treatment; and
- Create an ongoing structure that we can use to coordinate advocacy efforts as new opportunities arise in the future.

The Consortium includes medical and behavioral health care providers, Health Homes, housing and social service providers. Following the first meeting of the Consortium, several committees were convened to address specific concerns and goals of Consortium members. This Housing Referral Handbook is the product of the committee that focuses on health and housing organizations working together to integrate housing and health support for participants.

This Housing Referral Handbook is designed as a resource for providers assisting clients to apply for housing. It is intended to be a user friendly document that provides information about housing options, primarily for various special needs populations identified in the NY/NY III Agreement, as well as the first two NY/NY Agreements and other special needs housing options. Most of the options require a 2010e application through the NYC HRA Customized Assistance Services (CAS) Placement, Assessment and Client Tracking (PACT) Unit. The Handbook includes eligibility criteria and a step by step guide on how to make an application and follow through to achieve housing placement of the individual (or family) receiving services.

We are providing the most up-to-date contact information to the housing resources within the Bronx Health and Housing Consortium as well as information about the systems to be navigated to initiate a housing application. We also provide several resources for emergency situations.

The Handbook is a working document and will be updated regularly. We ask that you forward your comments and updates to: Sarah Gibney [sgibney@bronxworks.org](mailto:sgibney@bronxworks.org)

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## **SECTION 1 - OVERVIEW OF TYPES OF HOUSING, ELIGIBILITY AND ACCESS**

### **I. TYPES OF HOUSING**

**EMERGENCY HOUSING** is time limited varies from less than a month to many months

**TRANSITIONAL HOUSING** provides residents with an agreement that includes tenant rights and responsibilities, such as paying fees and complying with individual service plans. This agreement also defines the program operator's responsibilities: *It is not a lease.*

**CONGREGATE VS. SCATTER-SITE:** In Congregate housing, all units are located in one building. There are typically some shared facilities such as a community room, dining room, and laundry. In Scatter-Site housing, clients live in different apartment buildings among other non-supportive housing tenants.

**SPECIAL NEEDS HOUSING** is for specific groups of clients or tenants. It is generally referred to as Supportive Housing in NYC and it provides on-site support services for special needs clients or tenants. The support services are usually funded by the government office responsible for the services accessed, i.e. , the NYS Office of Mental Health for adults with a psychiatric disability, the Department of Homeless Services, and NYC HIV AIDS Services Administration (HASA).

**Permanent** housing for special needs populations is typically integrated with other tenants with units set aside for special needs populations. **Transitional** housing programs for special needs populations tend to be 100% special needs tenants.

**PERMANENT HOUSING** provides tenants with a lease.

**AFFORDABLE/SUBSIDIZED/LOW INCOME /INCOME RESTRICTED** are terms that are associated with various types of housing. There are a number of funding mechanisms associated with supportive housing that enable the housing operator to manage the building while tenants typically contribute either their HRA Public Assistance Housing Allowance (currently \$215/month) or 30% of their income as their portion of the rent. The remaining operating costs are covered by the funding sources associated with the building or the program including Tax Credits, SRO Support Subsidy, Section 8, etc. Scatter site programs can also be subsidized using operating contracts from the various special needs programs so that the program operator can rent units to serve the special need population and only charge them their housing allowance or 30% of their income as their portion of the rent.

## **CATEGORIES OF HOUSING**

### **Supervised Community Residences**

- ✓ TRANSITIONAL (*residency agreement*, not a lease)
- ✓ CONGREGATE
- ✓ SPECIAL NEEDS ONLY (Mental Health)
- ✓ 2010e

*Supervised Community Residences* are congregate care facilities which house approximately 10 to 24 residents; similar to a group home and are classified as Level II funded facilities. Level II is a funding enhancement certified by NYS. These programs are considered *transitional*, as their goal is to move residents to a less restrictive level of care within 18-24 months upon successful completion of the housing program. Rooms are often shared, but some community residences will have single rooms for residents as they advance in the program. Bathrooms are shared and all meals are served in the community dining room. They are licensed by the NYS Office of Mental Health and operated by nonprofit agencies.

### **Apartment Treatment Programs**

- ✓ TRANSITIONAL (*residency agreement*, not a lease)
- ✓ SCATTER-SITE
- ✓ SPECIAL NEEDS ONLY (Mental Health)
- ✓ 2010e

*Apartment Treatment Programs* provide **transitional housing** in the community in shared apartments, housing two to four people and are Level II funded facilities. Often they are scattered throughout the borough, but sometimes can be together in one building. Residents will either have their own bedroom or share larger bedrooms. Bathrooms and common areas are also shared. These programs are licensed by the NYS Office of Mental Health and operated by nonprofit agencies. They are considered transitional as they work with residents to graduate to more independent (less restrictive levels of care) housing within 18-24 months.

### **CR/SROs (Community Residence/Single Room Occupancy)**

- ✓ CONGREGATE
- ✓ “EXTENDED STAY” (*residency agreement*, not a lease)
- ✓ SPECIAL NEEDS ONLY (Mental Health)
- ✓ 2010e

*CR/SROs are congregate care, Level II funded facilities.* Level II is a funding enhancement certified by NYS. They are considered “**extended stay**” **housing programs**. In this model, residents typically stay between two and five years before they transition to a more independent (“less restrictive” setting). In many respects, CR/SROs are similar to Supported SROs, but have more on-site social service staff. CR/SROs typically are not larger than 100 beds (generally, residences have 35-65 units). Many CR/SROs have single rooms with shared baths (approximately one full bathroom for every five persons), a large central kitchen and additional kitchenettes on the floors. Some CR/SROs offer efficiency apartments with private baths. In most residences, each floor has a common space with one large community room for all residents. All residents receive occupancy or rental agreements. CR/SROs are operated by nonprofit agencies and certified by the NYS Office of Mental Health and

other agencies. The NYC Department of Health and Mental Hygiene (DHMH) is the lead agency contracting for the ongoing operation and support services for the City's share of NY/NY III housing, with the exception of the units designated for individuals with HIV/AIDS. These units are the responsibility of the NYC Human Resources Administration (HRA). DHMH also is contracting for the ongoing operation and support services with respect to a portion of the State's share of NY/NY III supportive housing.

### **Supportive SROs**

- ✓ PERMANENT (lease)
- ✓ CONGREGATE
- ✓ INTEGRATED - some special needs units and some low income/income restricted units for residents of the local community
- ✓ **2010e applications are required for special needs tenants only** (other applicants would submit an application to the housing management/landlord)

Supportive SROs provide **permanent housing** in single room occupancy (SRO) buildings. They vary greatly in size ranging from under 20 residents to over 600. All Supportive SROs offer leases to tenants for **furnished single rooms** that, in most cases, have recently been renovated. In some Supported SROs, bathrooms and/or kitchens are shared. Newer buildings offer "efficiency studios" with private bath and kitchenettes. Most Supported SROs are run by a nonprofit organization and receive funding for services from multiple sources, including the NYC Department of Health and Mental Hygiene (DOHMH), the NYC Department of Homeless Services (DHS), and/or the NYC HIV/AIDS Services Administration (HASA).

### **Safe Haven**

- ✓ EMERGENCY
- ✓ CONGREGATE
- ✓ SPECIAL NEEDS (*substance abuse, homeless with unaddressed illness/medical*)
- ✓ "EXTENDED STAY" (*residency agreement, not a lease*)

*Safe Haven* programs are extended-stay programs. They provide housing for individuals who are homeless and have not successfully engaged in conventional housing or outpatient treatment. Many have been diagnosed with a serious and persistent mental illness (SPMI). The primary goal of this housing model is to promote wellness and stability by providing housing and rehabilitative services in a low demand environment. Residents are permitted to remain as long as required while they acquire the skills necessary for independent living with the typical length of stay is two to five years.

## **NY/NY I, II, AND III HOUSING**

### **NY/NY I, II, and III Overview:**

#### **Housing for People Who Are Homeless with Mental Illness or Other Special Needs**

The first New York/New York agreement (**NY/NY I**) was signed between former Mayor Dinkins and former Governor Cuomo on August 22, 1990, provided housing and services to 5,225 homeless persons with mental illness from 1990-1993. Five hundred additional units were added to NY/NY I in 1993. These units are not often vacant.

In 1999 a second agreement (**NY/NY II**) was signed--adding 2,320 units of housing. These units have been developed by New York City and New York State under the terms of this agreement. The units were rolled out through 2004 and made available for individuals who are both **Seriously and Persistently Mentally Ill (SPMI) AND** homeless.

In 2005, a third agreement (**NY/NY III**) was signed, with the intent of adding 9,000 units of housing; 7,500 of these units for single adults, and 1,500 units for families. These units are being developed by New York City and New York State under the terms of this agreement, and will be rolled out through 2016.

Applicants for NY/NY III housing must currently be chronically homeless or at risk of homelessness, and have a mental illness, substance disorder or other special need. This housing may be transitional or lease-based, for individuals or families, with single or shared units.

Production goals of units are found in the table on the following page.



<b>NY/NY III Housing Unit Production Goals by Population:</b>			
<b>Population</b>	<b>Single-Site</b>	<b>Scattered-Site</b>	<b>Total</b>
A. Chronically homeless single adults who suffer from a serious and persistent mental illness or who are diagnosed as mentally ill and chemically addicted (MICA)	3,200	750	3,950
B. Single adults who are presently living in NYS-operated psychiatric centers or State-operated transitional residences and who could live independently in the community if provided with supportive housing and who would be at risk of street or sheltered homelessness if discharged without supportive housing	500	500	1,000
C. Young adults, ages 18-25, who have a serious mental illness being treated in NYS licensed residential treatment facilities, State psychiatric facilities or leaving or having recently left foster care, and who could live independently in the community if provided with supportive housing, and who would be at risk of street or sheltered homelessness if discharged without supportive housing.	200	0	200
D. Chronically homeless families, or families at risk of becoming chronically homeless, in which the head of the household suffers from SMI (severe mental illness) or a co-occurring Mental Illness and Chemical Addiction (MICA) disorder	400	0	400
E. Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living	250	500	750
F. Homeless single adults who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness, and who need transitional supportive housing (that may include half-way houses) to sustain sobriety and achieve independent living	250	500	750
G. Chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of the household suffers from a substance abuse disorder, a disabling medical condition, or HIV/AIDS	750	0	750
H. Chronically homeless single adults who are persons living with HIV/AIDS (who are clients of the NYC HIV/AIDS Services Administration (HASA) or who are clients with symptomatic HIV who are receiving cash assistance from the City) and who suffer from a co-occurring serious mental illness, a substance abuse disorder, or a MICA disorder	600	400	1,000
I. Young adults (aged 18-25) leaving or having recently left foster care or who had been in foster care for more than a year after their 16th birthdays and who are at risk of street homelessness or sheltered homelessness	100	100	200
<b>Total Units</b>	<b>6,250</b>	<b>2,750</b>	<b>9,000</b>

Note: Table created in Spring 2012—recent additional funding may increase these numbers and not all of the units have been developed at the present time.

#### **NY/NY III Overview of Populations:**

NY/NY III is an affordable, supportive housing program with a social services component, for nine distinct populations. This housing is either (1) “congregate”, where supportive services can be provided on-site within reach of the tenant, or (2) “scattered-site”, in which individual apartments are rented from existing market housing throughout the City. The program includes 9000 total units--6250 congregate units plus 2750 scatter-site units.

**Who Benefits?** The population served under NY/NY III is classified into 9 categories A through I as follows:

**Youth:**

- Population I: Young adults aged 18-25 years leaving or having recently left foster care or who had been in foster care for more than a year after their 16th birthdays and who are at risk of street homelessness or sheltered homelessness; and
- Population C: Young adults aged 18-25, who have a serious mental illness being treated in a State psychiatric facility or NYS licensed residential treatment facility and are leaving or having recently left foster care and who could live independently in the community if provided with supportive housing, and who would be at risk of street or sheltered homelessness if discharged without supportive housing assistance.

**Adults:**

- Population A: Chronically homeless single adults who suffer from a serious and persistent mental illness (SPMI) or who are diagnosed as mentally ill and chemically addicted (MICA);
- Population B: Single adults who are presently living in NYS-operated psychiatric centers or State-operated transitional residences and who could live independently in the community if provided with supportive housing and who would be at risk of street or sheltered homelessness if discharged without supportive housing;
- Population E: Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living and who also have a disabling clinical condition (i.e. a medical or mental health (non-SPMI) condition that further impairs their ability to live independently);
- Population F: Homeless single adults who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need transitional supportive housing (that may include half-way houses) to sustain sobriety and achieve independent living; and
- Population H: Chronically homeless single adults who are persons living with HIV/AIDS (who are clients of HASA or who are clients with symptomatic HIV who are receiving cash assistance from the City) and who suffer from a co-occurring serious and persistent mental illness, a substance abuse disorder, or a MICA disorder.

**Families:**

- Population D: Chronically homeless families, or families at risk of becoming chronically homeless, in which the head of the household suffers from SPMI or a MICA disorder; and
- Population G: Chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of the household suffers from a substance abuse disorder, a disabling medical condition, or HIV/AIDS.

## **NYNY III Housing—Application Process**

### **YOUTH:**

**Population I:** Young adults aged 18-25 years leaving or having recently left foster care or who had been in foster care for more than a year after their 16th birthdays and who are at risk of street homelessness or sheltered homelessness.

*How Many Units?* 200 total units: 100 congregate and 100 scatter-site

There are eight (8) NY/NYIII housing providers: four congregate and four scatter-site. The scattered site providers in the Bronx are JBFCS (the Jewish Board) and NCS (Neighborhood Coalition for Shelter). Jasper Hall is the congregate site located in Bronx; referrals to Jasper Hall are made by fax or e-mail.

**Population C:** Young adults aged 18-25, who have a serious mental illness being treated in a State psychiatric facility or NYS licensed residential treatment facility and are leaving or having recently left foster care and who could live independently in the community if provided with supportive housing, and who would be at risk of street or sheltered homelessness if discharged without supportive housing assistance.

### **How to Apply for I and C above**

Applications will go through HRA Customized Assistance Services- Placement Assessment and Client Tracking (PACT) Unit. The HRA 2010(e) must be completed and applications are only accepted electronically.

- To submit the HRA 2010e application, an agency must be trained by HRA and receive a username and password
- A complete HRA application package includes:
  - HRA housing application
  - A comprehensive psychosocial summary, completed within 6 months of the application submission date
  - Tuberculosis testing results (PPD) within a year of the 2010e submission date
  - If the applicant is mentally ill: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist or nurse practitioner, and completed within 6 months of the 2010e application date. If the client has a substantive mental health history the psychiatric evaluation needs to include a complete mental status examination and be very specific about reasons for psychiatric hospitalizations, homicide and suicide attempts and ideation, danger to self or others, and current medications.
  - For youth who have left foster care, it is expected that their last case planning agency will assist them to complete the documentation.

### **Process**

Once an application is submitted, HRA determines eligibility for the program and which level of housing is deemed appropriate. Youth who fall into the following 2 categories will have their applications and eligibility determination routed to the Children's Services Housing Support and Services Unit:

- Young adults (aged 25 years or younger (18-25) leaving or having recently left foster care or who had been in foster care for more than a year after their 16th birthdays and who are at risk of street homelessness or sheltered homelessness, and

- Young adults, ages 18-25, who have a serious mental illness being treated in NYS licensed residential treatment facilities, State psychiatric facilities or leaving or having recently left foster care and who could live independently in the community if provided with supportive housing and who would be at risk of street or sheltered homelessness if discharged without supportive housing.
- In addition, youth who are still in foster care who fall into any other category will have their applications sent to Children's Services.

Youth not in care or who were never in care and who fall into any other category, along with families and single adults will have their applications routed to DHS for processing.

Housing Support and Services will prioritize applicants based on need and match clients with available housing. Once housed, youth will receive services through this program. They can stay in their apartment until their 26th birthday, during which time they will be assisted in finding permanent housing.

### **Contact Housing Support Services for each of the Categories**

#### **Population I:**

Paul Williams

Client Support Specialist

(212) 676 6779

[Paul.williams@dfa.state.ny.us](mailto:Paul.williams@dfa.state.ny.us)

Once a NY/NY III application is submitted by an entity trained and sanctioned by HRA, an approval typically comes within three days. A letter of determination, detailing the approval, is then sent to the party who initiated the 2010e electronic application with instruction to contact the administrator of the approved category.

Paul Williams is currently the administrator of Population I, and as such, he is responsible for making all electronic referrals to the eight available housing providers. *Each individual provider establishes his or her own waiting list.*

Young adults and Case Planners are responsible to follow up with provider with respect to the movement of a particular waiting list.

The Housing Support Services office is located at 150 William Street, 8th floor in Manhattan. The Housing Support Specialists are available Monday-Friday from nine to five. In order to expedite the processing of relevant housing forms, the Case Planner/Case Manager should accompany families to their office.

## ADULTS

**Population A:** Chronically homeless single adults who suffer from a serious and persistent mental illness (SPMI) or who are diagnosed as mentally ill and chemically addicted (MICA). A chronically homeless person is one who has spent at least one of the last two years in a homeless shelter or living on the street.

### How to Apply

Applications will go through HRA Customized Assistance Services- Placement Assessment and Client Tracking (PACT) Unit. The HRA 2010(e) must be completed and applications are only accepted electronically.

- To submit the HRA 2010e application, an agency must be trained by HRA and receive a username and password
- A complete HRA application package includes:
  - HRA housing application
  - A comprehensive psychosocial summary, completed within 6 months of the application submission date
  - Tuberculosis testing results (PPD) within a year of the 2010e submission date
  - Letter from residence indicating that the setting is transitional
  - If the applicant is mentally ill: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist or nurse practitioner, and completed within 6 months of the 2010e application date. If the client has a substantive mental health history the psychiatric evaluation needs to include a complete mental status examination and be very specific about reasons for psychiatric hospitalizations, homicide and suicide attempts and ideation, danger to self or others, and current medications.

### CONTACT

Jose Correa  
Program Manager  
(212) 361 0941  
[jcorrea@dhs.nyc.gov](mailto:jcorrea@dhs.nyc.gov)

Mr. Correa manages the central waiting list, but programs can be contacted directly to review vacancy information. **There are vacancies in these units** as of May 2012 so it is helpful to follow up with these calls.

## ADULTS

**Population B:** Single adults who are presently living in NYS-operated psychiatric centers or State-operated transitional residences and who could live independently in the community if provided with supportive housing and who would be at risk of street or sheltered homelessness if discharged without supportive housing;

Population B is chronically homeless single adults who have a serious mental illness or who are diagnosed as mentally ill and chemically addicted (MICA).

### How to Apply

Applications will go through HRA Customized Assistance Services- Placement Assessment and Client Tracking (PACT) Unit. The HRA 2010(e) must be completed and applications are only accepted electronically.

- To submit the HRA 2010e application, an agency must be trained by HRA and receive a username and password
- A complete HRA application package includes:
  - HRA housing application
  - A comprehensive psychosocial summary, completed within 6 months of the application submission date
  - Tuberculosis testing results (PPD) within a year of the 2010e submission date
  - Proof of homeless status letter from shelter, outreach team, drop in center
  - If the applicant is mentally ill: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist or nurse practitioner, and completed within 6 months of the 2010e application date. If the client has a substantive mental health history the psychiatric evaluation needs to include a complete mental status examination and be very specific about reasons for psychiatric hospitalizations, homicide and suicide attempts and ideation, danger to self or others, and current medications.

## Single Point of Access (SPOA)

SPOA helps eligible applicants obtain a unit in the state-funded mental health supportive housing system in NYC. Clients approved for housing under Population B need a SPOA application. See *page 27 for a description of this program.*

Referring agencies can fax or mail a copy of the complete HRA Housing Application packet to:

CUCS (Center for Urban Community Services)  
198 East 121st Street, 6th Floor  
New York, NY 10035  
Fax: 212-635-2183

Packets sent to CUCS should include the form titled SPOA Housing Application. CUCS sends the referral source the SPOA Referral Report, which lists up to three referrals. The referring agency sends complete copies of the approved 2010e to the SPOA identified agencies and they will arrange intakes/interviews. If none of the 3 interviews results in an acceptance, there is a case conference to determine next steps to support the person to get housing.

If accepted into the housing program, there is typically a waiting list that can last several months. Additionally, the housing providers request additional information and want proof that the SSI application has been submitted, although not necessarily approved.

## ADULTS

**Population E:** Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living. Chronically homeless is defined as homeless for 6 of the past 12 months.<sup>1</sup> This housing is sometimes referred to as “harm-reduction housing”.

## How to Apply

Applications will go through HRA Customized Assistance Services- Placement Assessment and Client Tracking (PACT) Unit. The HRA 2010(e) must be completed and applications are only accepted electronically.

- To submit the HRA 2010e application, an agency must be trained by HRA and receive a username and password
- A complete HRA application package includes:
  - HRA housing application
  - A comprehensive psychosocial summary, completed within 6 months of the application submission date
  - Tuberculosis testing results (PPD) within a year of the 2010e submission date
  - Proof of homeless status letter from shelter, outreach team, drop in center

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<sup>1</sup> Effective April 13, 2009, there were two changes in eligibility criteria: Individuals who have been homeless 6 of the past 12 months are considered eligible; the second change was that clients are no longer required to have a disabling clinical condition.

- If the applicant is mentally ill: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist or nurse practitioner, and completed within 6 months of the 2010e application date. If the client has a substantive mental health history the psychiatric evaluation needs to include a complete mental status examination and be very specific about reasons for psychiatric hospitalizations, homicide and suicide attempts and ideation, danger to self or others, and current medications.

**CONTACT**

Jose Correa

Program Manager

(212) 361 0941

[jcorrea@dhs.nyc.gov](mailto:jcorrea@dhs.nyc.gov)



## ADULTS

**Population F:** Homeless single adults who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need transitional supportive housing (that may include half-way houses) to sustain sobriety and achieve independent living.

### How to Apply

Applications will go through HRA Customized Assistance Services- Placement Assessment and Client Tracking (PACT) Unit. The HRA 2010(e) must be completed and applications are only accepted electronically.

- To submit the HRA 2010e application, an agency must be trained by HRA and receive a username and password
- A complete HRA application package includes:
  - HRA housing application<sup>2</sup>
  - A comprehensive psychosocial summary, completed within 6 months of the application submission date
  - Tuberculosis testing results (PPD) within a year of the 2010e submission date,
  - Letter from substance abuse treatment provider indicating date of admission, program requirements/schedule, and that random toxicology testing indicates that the client has tested negative for illicit substances for at least 90 days<sup>3</sup>,
  - Letter from residence indicating that the setting is transitional<sup>4</sup>, and
  - If the applicant is mentally ill: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist or nurse practitioner, and completed within 6 months of the 2010e application date. If the client has a substantive mental health history the psychiatric evaluation needs to include a complete mental status examination and be very specific about reasons for psychiatric hospitalizations, homicide and suicide attempts and ideation, danger to self or others, and current medications.<sup>5</sup>

## CONTACT

Jose Correa  
Program Manager  
(212) 361 0941  
[jcorrea@dhs.nyc.gov](mailto:jcorrea@dhs.nyc.gov)

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2 The application includes information about source of income. The housing providers strongly prefer employed clients.

3 Note: If client's documented "clean time" is in excess of 12 months, they are likely to be deemed ineligible for housing under NY/NY III because they do not have substance abuse issue. Some providers want clients who are attending self help meetings on a regular basis and are working actively with a sponsor.

4 If client is not homeless or in a transitional residence the application can be strengthened by indicating how the current housing situation puts the client at risk of relapse.

5 If the psychiatric illness is serious the "F" housing providers are unlikely to accept the applicant into their program. These individuals typically do not meet NY/NYIII definitions for Population "A" due to limited homeless history and are referred to non NY/NY housing using the SPOA process. [See population B for details.]

Mr. Correa manages the central waiting list, but programs can be contacted directly to review vacancy information. The list is on the following page.

### **OASAS FUNDED NYNY III HOUSING PROVIDERS**

OASAS (Office of Alcoholism and Substance Abuse Services) is the designated single state agency responsible for the coordination of state-federal relations in the area of addiction services. OASAS plans, develops and regulates the state's system of chemical dependence and gambling treatment agencies. This includes the direct operation of 12 Addiction Treatment Centers, which provide inpatient rehabilitation services to 10,000 persons per year. In addition, the Office licenses, funds, and supervises some 1,300 local, community-based, chemical dependence treatment programs, which serve about 110,000 persons on any given day in a wide range of comprehensive services. The agency inspects and monitors these programs to guarantee quality of care and to ensure compliance with state and national standards.

OASAS funds housing providers to support this population in NYNY III supportive housing—  
Population F.

## OASAS Funded NYNY III Housing Providers

### [BASICS](#)

1064 Franklin Avenue  
Bronx, New York 10456  
(718) 764-1501  
Serves Single Adults and Families

### [Brooklyn AIDS Task Force](#)

502 Bergen Street  
Brooklyn, New York 11217  
(718) 622-2910  
Serves Single Adults and Families

### [Bowery Residents' Committee](#)

324 Lafayette Street 8th Floor  
New York, New York 10012  
(646) 602-0706  
Serves Single Adults

### [The Fortune Society](#)

39 W. 19th Street  
New York, New York 10456  
(212) 691-7554  
Serves Single Adults

### [Housing + Solutions, Inc.](#)

3 West 29th Street  
Suite 805  
New York, NY 10001  
(212) 213-0221  
Serves Families

### [Lower Eastside Service Center, Inc.](#)

80 Maiden Lane 2nd Floor  
New York, New York 10038  
(212) 566-7782  
Serves Single Adults

### [Narco Freedom, Inc.](#)

20 Grand Concourse 2nd Floor  
Bronx, New York 10451  
(718) 292-2240  
Serves Single Adults

### [Odyssey House](#)

95 Pine Street 17th Floor  
New York, New York 10005  
(212) 361-1608  
Serves Single Adults and Families

### [Palladia, Inc.](#)

2006 Madison Avenue  
New York, New York 10035  
(212) 979-8800 Ext. 254  
Serves Single Adults and Families

### [Project Hospitality](#)

100 Park Avenue  
Staten Island, New York 10302  
(718) 445-1544 Ext. 103  
Serves Single Adults

### [Project Renewal](#)

200 Varick Street  
New York, New York 10014  
(212) 620-0340  
Serves Single Adults

### [Turning Point](#)

200 Varick Street  
New York, New York 10014  
(212) 620-0340  
Serves Single Adults

### [Women In Need](#)

115 West 31<sup>st</sup> Street  
New York, NY 10001  
(212) 695-4758  
Serves Families Category G

**OASAS FUNDED PROGRAMS****CONTACT LIST FROM JOSE CORREA AT DHS FOR POPULATION F (MAY 2012)**

BASICS	Margo Gill (Program Supervisor / Coordinator)	646-224-0486/0448
BRC	Deborah Santana-Davis, MPA (Program Supervisor)	718-402-3875 office
Brooklyn Aids Task Force	Eileen Sunshine (Program Manager)	718-622-2910
Turning Point	Victoria Brown (Program Director)	(718) 473-3881
Lower East Side Service Center	Sandra Spence	347-226-3406
Narco Freedom, Inc.	Evelyn Munoz (Program Director)	718-585-5204 x283
Odyssey House	Janice Glenn Slaughter (Program Director)	(917) 492-2580
Palladia Inc	Sharon Coates (Program Manager)	212 979-8800
Project Hospitality, Inc.	Elissa Donner	(718) 273-8409 x22
Project Renewal	Katie Bower (Director of Transitional Housing)	212-234-1129
The Jericho Project (Probation)	Debbie Modeste	(718) 538-5494

## ADULTS

**Population H:** Chronically homeless single adults who are persons living with HIV/AIDS (who are clients of HASA or who are clients with symptomatic HIV who are receiving cash assistance from the City) and who suffer from a co-occurring serious and persistent mental illness, a substance abuse disorder, or a MICA disorder.

### **NY/NYIII units in the Bronx**

*(population "H" all single adults)*

121 --scatter-site units

62 --congregate units (typically supportive SRO)

*183 total units*

### **HASA Permanent**

*(single units)*

550 --scatter-site units

560 --congregate units (typically supportive SRO)

*1010 total units*

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HASA cannot release list of providers because they see that as a breach of confidentiality. To receive any housing assistance, someone who has AIDS symptoms or who is HIV+ needs to become a HASA client by applying in person at their intake office at **300 8<sup>th</sup> Avenue in Manhattan**. When they are accepted, they are assigned a case manager who is based in one of 12 centers.

**Transitional Housing Placements** in either non-profit managed SROs and/or Commercial SROs are made through the Emergency Placement Unit of HASA.

- Clients come to centers where their case managers are based and report that they are homeless.
- They are assessed by the Comprehensive Health Assessment Team (CHAT): there is a CHAT worker at each center. The CHAT workers are clinicians who conduct assessments and complete the 2010e Housing Application for population "H". They submit the Application to the HRA CAS office for review and approval.

While the 2010e is pending, the client is referred by HASA to a transitional placement<sup>1</sup>

### **Housing Placement**

#### **CONTACT**

John Ruscillo  
Director of Housing Services  
(212) 620 9830  
[ruscilloj@hra.nyc.gov](mailto:ruscilloj@hra.nyc.gov)

Deborah McKeever  
Deputy Director of Housing Services  
(212) 620 4666  
[mckeeverd@hra.nyc.gov](mailto:mckeeverd@hra.nyc.gov)

### ***NY/NY III***

- NYC HRA Customized Assistance Services (CAS) notifies HASA Housing Services office that 2010e is approved.
- Ms. McKeever instructs the HASA Case Manager to complete the HASA housing application as it is required for all of the HASA funded units, both NY/NY III and non NY/NY III units.
- Ms. McKeever reviews the/an internal vacancy list for available units and makes one referral at a time. So, one 2010e application with the HASA housing application is submitted to one housing provider and is screened. Ms. McKeever alerts the HASA Case Manager and the HASA housing specialist of each referral. The client is interviewed. Ms. McKeever reviews updated vacancy lists to determine if client was accepted. If not accepted she makes referral to next available NY/NYIII housing provider.
- If client declines the NYNY III units and is in HASA, s/he can be referred to other HASA housing options based upon availability. Only the HASA housing application is required. It is completed by the HASA Case Manager.
- HASA follows the same procedure of sending referrals to available housing providers based upon internal lists of available units.

## FAMILIES

**Population D:** Chronically homeless families, or families at risk of becoming chronically homeless, in which the head of the household suffers from SPMI or a MICA disorder.

**How many units?** *400 congregate units*

### How to Apply

Applications will go through HRA Customized Assistance Services- Placement Assessment and Client Tracking (PACT) Unit. The HRA 2010(e) must be completed and applications are only accepted electronically.

- To submit the HRA 2010e application, an agency must be trained by HRA and receive a username and password
- A complete HRA application package includes:
  - HRA housing application
  - A comprehensive psychosocial summary, completed within 6 months of the application submission date. The application is written about the adult who qualifies the family for the housing.
  - Tuberculosis testing results (PPD) within a year of the 2010e submission date
  - If the applicant is mentally ill: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist or nurse practitioner, and completed within 6 months of the 2010e application date. If the client has a substantive mental health history the psychiatric evaluation needs to include a complete mental status examination and be very specific about reasons for psychiatric hospitalizations, homicide and suicide attempts and ideation, danger to self or others, and current medications.

## CONTACT

Maria A. Rodriguez

Director of Special Projects

(212) 607 6085

[mzrodig@dhs.nyc.gov](mailto:mzrodig@dhs.nyc.gov)

## Provider Agencies for Population D Housing

Common Ground	<a href="http://www.commonground.org">www.commonground.org</a>
Help USA	<a href="http://www.helpusa.org">www.helpusa.org</a>
St. John's Community Housing	(718) 402-3704 1182 Washington Ave # 1J Bronx, NY 10456
Lantern	<a href="http://www.lanterngroup.org">www.lanterngroup.org</a>
Geel	<a href="http://www.geelcommunityservices.org">www.geelcommunityservices.org</a>
Veterans Administration	LaTonya Heyward, Program Manager at 718-584-9000 x5154, or check the Veteran's Industries website at <a href="http://www.va.gov/vi-bronx">www.va.gov/vi-bronx</a>



## FAMILIES

**Population G:** Chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of the household suffers from a substance abuse disorder, a disabling medical condition, or HIV/AIDS.

In addition to the NYNY III units:

### **HASA Permanent Housing in the Bronx**

*(family units)*

151 families—*scatter-site*

46 families—*congregate-facility (single site)*

197 total units

### **How to Apply**

Applications will go through HRA Customized Assistance Services- Placement Assessment and Client Tracking (PACT) Unit. The HRA 2010(e) must be completed and applications are only accepted electronically.

- To submit the HRA 2010e application, an agency must be trained by HRA and receive a username and password
- A complete HRA application package includes:
  - HRA housing application
  - A comprehensive psychosocial summary, completed within 6 months of the application submission date
  - Tuberculosis testing results (PPD) within a year of the 2010e submission date, and
  - If the applicant is mentally ill: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist or nurse practitioner, and completed within 6 months of the 2010e application date. If the client has a substantive mental health history the psychiatric evaluation needs to include a complete mental status examination and be very specific about reasons for psychiatric hospitalizations, homicide and suicide attempts and ideation, danger to self or others, and current medications.

### **CONTACT**

Maria A. Rodriguez

Director of Special Projects

(212) 607 6085

[mzrodiq@dhs.nyc.gov](mailto:mzrodiq@dhs.nyc.gov)

## Population G Housing

Postgraduate Center for Mental Health (PCMH)	<a href="http://www.pgcmh.org">www.pgcmh.org</a> 212-560-6711
Palladia	<a href="http://www.palladiainc.org">http://www.palladiainc.org</a>
Church Avenue Merchants Block Association (CAMBA)	<a href="http://www.camba.org">www.camba.org</a>
Fortune Society	<a href="http://www.fortunesociety.org">www.fortunesociety.org</a>
Lantern	<a href="http://www.lanterngroup.org">www.lanterngroup.org</a>
Lower Eastside Service Center (LESC)	<a href="http://www.lesc.org">www.lesc.org</a>
Volunteers of America (VOA)	<a href="http://www.voa.org">www.voa.org</a>

## **II. SINGLE POINT OF ACCESS (SPOA) HOUSING OVERVIEW**

### **What is Single Point of Access (SPOA)?**

The SPOA program utilizes a centralized database to connect eligible applicants with appropriate vacancies in the mental health housing system in Brooklyn, Bronx, Manhattan, Queens and Staten Island. SPOA gathers data on housing needs and the availability of services for consumers with special needs, and improves access to housing and related services for people with psychiatric disabilities. SPOA collects information on the housing referral process and movement through the housing system. The overall goals of the program are to improve access to housing and related services for people with psychiatric disabilities and to collect data on housing needs and the availability of services for consumers with special needs.

### **What is the role of NYS Office of Mental Health?**

As a central element of the NYS OMH Evidence Based Practices Initiative, OMH has developed similar SPOA programs in counties throughout New York State. Along with consumer and provider representatives, OMH has worked to design and implement New York City's SPOA program.

### **What is the SPOA Housing Program and who is eligible to participate?**

The SPOA program began in August 2001 in Brooklyn. The pilot expanded to the Bronx in January 2003, Staten Island in March 2003, Queens in April 2003 and Manhattan in September 2003. As of September 2003, SPOA is a citywide system, encompassing all five New York City boroughs. Applicants are eligible for SPOA if they have a serious mental illness and are not New York/New York I or II eligible. An applicant may be eligible for SPOA if they have New York/New York III eligibility because they have a serious mental illness and are being discharged from a NYS-operated psychiatric center or NYS-operated transitional residence or residential treatment facility and are at risk of homelessness. In addition, the applicant must have requested Brooklyn, Bronx, Manhattan, Queens or Staten Island as a borough preference or have a last known address or family within the five boroughs of New York City.

### **What is the role of the Center for Urban Community Services (CUCS)?**

CUCS has been contracted to provide administrative support to the SPOA program. Using an extensive database that tracks housing vacancies and services offered by housing providers, CUCS assists consumers and their referring workers in locating a program that most closely meets the applicants' needs and preferences. CUCS' team of Housing Consultants reviews each HRA Housing application, consults with the referring worker, then uses the housing database to generate three housing referrals for each applicant. CUCS also tracks and reports placement information to NYS OMH. In addition, CUCS provides training for referral sources and housing providers on the technical and clinical aspects of the housing referral process and participates in the SPOA case planning meetings.

### **How does SPOA impact consumers?**

Some mental health consumers have been unable to access housing in the existing mental health housing system. Under the SPOA program, consumers with special service needs may be eligible to receive OMH funded enhanced services, thereby increasing the likelihood that they will be accepted into a housing program. In addition, SPOA guarantees the consumer will be interviewed by all SPOA referred housing providers. SPOA significantly expands information available about who is getting access and who is not getting access to mental health housing. The data gathered helps to determine what types of services should be developed in the future to better meet the housing needs of all mental health consumers.

### **How does SPOA impact housing providers?**

Housing providers interview all applicants with complete HRA Housing Application packets that have been referred by SPOA. Providers will continue to assess and accept/reject applicants using their own agency criteria. Housing providers will have the opportunity to request enhanced services for a period of time as a condition of accepting an applicant. In cases where all three providers decline an application, CUCS will notify the providers and referral source of the date of the next SPOA case planning meeting.

### **How does SPOA impact referral sources?**

Referral sources continue to have the ability to request a specific residence or make referrals outside the SPOA process. For individuals who are eligible for the Single Point of Access Program, referral sources submit the HRA Housing Application packet to both HRA/OHMHS (NYC Human Resources Administration/Office of Health and Mental Health Services) and to CUCS. Referral sources have access to CUCS housing consultants, who consult on the case, offer any necessary technical assistance and provide three referrals upon receipt of the approval letter from the referring worker. The process of determining which housing programs best match an applicant's needs is collaborative and incorporates consumer preferences and referral source recommendations. In most cases, the applicant receives three referrals to housing providers and is guaranteed three interviews. By centralizing and standardizing the process, SPOA is intended to make referrals more efficient and expedient. In addition, SPOA offers enhanced services to facilitate access to housing for people that present extensive needs.

### **What types of enhanced services are available?**

In order to accommodate the diverse needs of consumers, OMH has not developed a pre-set menu of enhanced services. OMH is willing to consider funding any reasonable request for a service that would help a consumer succeed in housing. Examples of enhanced services that can be requested include, but are not limited to, bridger case management and temporary additional staffing. All requests for enhanced services will be reviewed and approved/rejected by OMH. All funding for enhanced services will be connected to the consumer, so that funding will be discontinued if the consumer leaves the program or no longer requires the service.

### **What is the purpose of and who attends SPOA case planning meetings?**

In cases where an applicant is rejected after an interview by all three housing providers, the Referral Source may request a case planning meeting by notifying CUCS. CUCS coordinates the date for the case planning meeting with those who will be present at case planning meetings, including: an OMH representative, representatives from each of the three housing provider agencies that received referrals, CUCS representatives, and when applicable, representatives from other agencies available to provide services. The consumer and a representative of the referring agency are strongly encouraged to participate. When necessary, a conference call can be arranged to facilitate consumer/referral source participation. The case planning meeting may result in any of the following: an approval for enhanced services resulting in housing placement, a decision to generate new referrals to housing programs, or the development of an alternative service plan.

Above information is from [www.CUCS.org](http://www.CUCS.org) website

When you need help:

Contact CUCS for help with cases -- (212) 801-3333

The NYS Office of Mental Health supports people who need Category A, B and soon C -- (212) 330-1650

**Jill Massey**

Brooklyn & Staten Island Borough Coordinator  
212 330 1665

[Jill.massey@omh.state.ny.us](mailto:Jill.massey@omh.state.ny.us)

**Susan Friedlander**

Queens Borough Coordinator  
(212) 330-6373

[Susan.friedlander@omh.state.ny.us](mailto:Susan.friedlander@omh.state.ny.us)

**Janyce Jones**

Bronx & Manhattan Borough Coordinator  
(212) 330-1664

[Janyce.jones@omh.state.ny.us](mailto:Janyce.jones@omh.state.ny.us)

### **III. GUIDE TO COMPLETING THE HRA 2010E NYC SUPPORTIVE HOUSING REFERRAL APPLICATION**

Below is a section by section outline of the HRA 2010e electronic housing application, highlighting key issues to keep in mind when completing the HRA 2010e online:

#### **Demographic Data**

- Name including alias, Address, Borough, Family Composition (if application is for a family) SSN, DOB, Gender, Income/Entitlements, Education, Marital Status, Ethnicity, Primary Language, Citizenship, Important Contacts
- Verification that the HIPAA Compliant Authorization is signed by applicant and the agency has a record of the original form
- Include details of any current legal involvement and history of convictions

#### **Housing/Homeless History**

- Current Housing Location; Housing/Homeless history including dates; Housing type; Facility name; Street Address. If applicant was homeless on the streets or non municipal shelters, documentation must be attached to the application providing more specific information including dates of homelessness and description of homelessness (places stayed), The more specific the better.

#### **Clinical Assessment**

- Multi-axial format outlined by the DSM-IV-TR \_ Axis I & II: psychiatric diagnoses. This information is obtained from the psychiatric evaluation \_ Axis III: Medical conditions. This information is obtained from the applicant's medical records, charts or self reports
- Assistive Outpatient Treatment (AOT) or Assertive Community Treatment (ACT) status

#### **Activities of Daily Living**

- Check any ADLs the applicant may require assistance with due to a medical or mental health conditions previously indicated. Provide explanation for any items checked. List includes: Feeding and Meal Preparation; Housekeeping; Managing Finances; Personal Hygiene; Traveling; Hearing; Sight; Cognitive Functions

#### **Medications**

- List names of psychotropic and non-psychotropic medication(s) in appropriate category(ies)
- Indicate level of support applicant will need to maintain medication compliance once he/she is housed

#### **Current Treatment/Service Providers**

- List of applicant's current treatment and service providers, including, but not limited to, medical, mental health and case management services providers/programs

#### **Domestic Violence**

- If applicant was a victim of DV, information about the services received and how long ago the DV occurred

#### **Hospitalization History**

- Age of first psychiatric hospitalization; number of psychiatric hospitalizations in the past 3 years; Name of hospital, dates of admission/discharge and service (psychiatric or medical)

#### **Tuberculosis Testing**

- Tuberculosis test results (PPD or chest X-Ray) require the signature of a physician, physician assistant or nurse practitioner; test results must be within the past year

#### **Symptoms/Behaviors**

- Select either "Current", "History", "Never" or "Unknown" for each Symptom/Behavior:
- Homicidal Ideation/Attempts; Suicidal Ideation/Attempts; Violent Behavior; Disruptive Behavior; Criminal Activity/Arrests; Arson/Firesetting; Cognitive Impairment; Hallucinations; Delusions; Thought Disorder; Clinical Depression
- Provide an explanation for all current and past symptoms/behaviors in the psychosocial summary and psychiatric evaluation

### **Symptoms/Substance Abuse**

- Select any/all substances applicant is currently abusing: Alcohol; Amphetamines; Cocaine; Crack; Hallucinogens; Opiates; Marijuana/Cannabis/THC; PCP; Sedatives/Hypnotics; if other, specify
- Describe pattern of abuse (daily, several times/week, binge etc.)
- Select the substances applicant used in the past (same list as above) and the pattern of abuse
- Indicate period of sobriety for Alcohol and for Drugs
- If applicant is currently in a substance abuse treatment program, provide information
- If applicant completed or participated in substance abuse treatment, provide information
- Provide detailed information in the psychosocial summary

### **Referring Agency Recommendations**

- Select the model or models of housing that is most appropriate for the applicant from the list of Housing Categories:
  - Community Care: Supported Housing & Supported SROs
  - Level I: Family Type Home for Adults
  - Level II: Various models of congregate care and congregate support housing
- Indicate services that applicant will need once he/she is housed. List includes: Ongoing Psychiatric Treatment; Substance Abuse Treatment; Self-Help Group; 24-hour Staff Supervision; Medication Management; Case Management/ACT Services; Assisted Out-Patient Treatment; Money Management; Day Treatment/Psychiatric Rehabilitation; Psychosocial/Clubhouse Program; Ongoing Medical Treatment; Special Medical Equipment/Services; Nursing/Home Health Services; Therapeutic Diet; Wheelchair/Handicap Access; Assistance with Housekeeping/Home Care Services; Education, Training, Job Readiness and Employment; Child Care; Domestic Violence Services; Meals Provided; Parenting Skills Training

### **Applicant's Housing Preferences**

- This section is for applicant's input regarding his/her preferences for housing. List includes preferences on the following (Y/N): Borough and neighborhood preference(s); sharing a room or apartment; sharing a bathroom with other people; preparing one's own food or having meals prepared; willingness to live in a residence where money is managed; willingness to live in housing which requires participation in a community based treatment program; willingness to live in a place where someone would help manage medications; whether assistance is needed with personal hygiene, traveling, keeping room clean or laundry; preference for overnight visitors; willing to live in a residence with a curfew; interested in educational/vocational opportunities; interested in residential sponsored social/recreational activities; and level of staff support the applicant wants
- Applicant's signature in this section indicates that applicant understands that his/her preferences are considered along with the recommendations of the referring worker as well as housing availability
- Applicant preferences should be clarified, when needed, in the psychosocial summary

### **Referring Agency Information**

- Referring Worker's Name, Title and Contact Information; Agency Name; Site Name; Address; Type of Site
- Affirmation that information provided is accurate

## New York/New York I and II

### How to Apply

Applications will go through HRA Customized Assistance Services- Placement Assessment and Client Tracking (PACT) Unit. The HRA 2010(e) must be completed and applications are only accepted electronically.

- To submit the HRA 2010e application, an agency must be trained by HRA and receive a username and password
- A complete HRA application package includes:
  - HRA housing application
  - A comprehensive psychosocial summary, completed within 6 months of the application submission date
  - Tuberculosis testing results (PPD) within a year of the 2010e submission date,
  - Letter from residence indicating that the setting is transitional, and
  - If the applicant is mentally ill: a comprehensive psychiatric evaluation, signed and dated by a psychiatrist or nurse practitioner, and completed within 6 months of the 2010e application date. If the client has a substantive mental health history the psychiatric evaluation needs to include a complete mental status examination and be very specific about reasons for psychiatric hospitalizations, homicide and suicide attempts and ideation, danger to self or others, and current medications.
- After receipt of an approval letter, contact **CUCS/RPMs at (212) 801-3333** for housing referrals, based on the needs and preferences of the applicant and the available vacancies in the various housing programs.
- Contact housing providers and make referrals. Generally providers will want a copy of the HRA application packet as submitted to HRA and the approval letter received from HRA. In some cases additional materials will be requested.
- Applicants will be contacted for interviews with staff and sometimes other residents. Interviews will often include questions about the information contained in the HRA application packet and applicants should be familiar with these materials. Prior to final acceptance by a housing program, an applicant can often expect a second interview.

For more detail follow the link to the CUCS web site:

<http://www.cucs.org/storage/documents/howtoaccessnyny.pdf>



#### **IV. VACANCY AND INFORMATION UPDATE**

The Vacancy and Information Update is published by the Residential Placement Management System (RPMs) of the CUCS Housing Resource Center and is supported by the NYC Department of Mental Health, Mental Retardation and Alcoholism Services.

The Vacancy Update has announcements, including information about new programs opening and changes in the housing system. Following the announcements is the list of programs serving individuals with a primary psychiatric diagnosis. The list is sorted by borough and level of care, indicating any special referral requirements.

The link to the Vacancy Update:

<http://www.cucs.org/referral-center/housing-placement-assistance/housing-vacancy-update>

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#### **HOUSING PLACEMENT ASSISTANCE**

Since 1987, CUCS' Housing Resource Center (HRC) has provided information and access to housing for homeless people with psychiatric disabilities and other special needs.

- [New York/New York Referral Assistance Program](#) provides trained telephone housing consultants responding to more than 9,000 inquiries a year from service organizations and social workers, advocates, family members, and homeless people themselves.
- [Single Point of Access \(SPOA\) Housing Program](#) helps to connect specifically identified applicants to the most appropriate residences and services.

The link to the housing placement assistance:

<http://www.cucs.org/referral-center/housing-placement-assistance>

## V. HEALTH INFORMATION TOOL FOR EMPOWERMENT (HITE)

[www.hitesite.org](http://www.hitesite.org)

HITE is an online resource for social service workers, discharge planners, and other information and referral providers. HITE's comprehensive directory helps the health and social services workforce provide fast, accurate linkages for uninsured and low-income individuals in the community.

To find housing resources in the Bronx,

- Open the site
- Left hand side—select Search for Programs & Services
- Scroll down
- Select Social Services
- Select Housing/homeless services/shelter

Although you cannot select by borough, if you input a Bronx zip code and a 10 mile radius most the Bronx resources will appear.

The Bronx Health and Housing Consortium will be working with HITE to ensure that Bronx resources are included in this data base.

## **SECTION 2- KEY BRONX ORGANIZATIONS/HOUSING RESOURCES**

### **I. KEY ORGANIZATIONS- INTAKE POINTS FOR HOMELESS PEOPLE**

A DHS Guiding Principle states that all homeless individuals and families deserve safe, temporary shelter and that planning for permanent housing should begin immediately. To enter a shelter, single homeless men or women who are 18 and older first must go to an intake facility. Homeless individuals who have been in a shelter within the past 12 months should return to their previous shelter placement. Otherwise, they should go to an intake center. The intake facilities for single adults are open 24 hours, seven days a week, including holidays. Bringing ID is strongly suggested, though not required. The following forms of ID are very helpful during the intake process:

- Any form of ID with a picture and proof of age - such as a driver's license, state-issued ID, passport or visa, welfare card or green card
- Social Security card
- Medicaid card, if available
- If working, the most recent pay stub

Interpreter assistance will be made available for people who do not speak English.

#### **Men and Couples with no children over 21 years of age**

##### **30th Street Intake**

400-430 East 30th Street/1st Avenue  
Entrance is now at 30th St. and 1st Avenue  
Manhattan

##### *Directions:*

Subway: Take the 6 train to 28th St., and walk to 30th St and 1st Ave.  
Get directions from [www.hopstop.com](http://www.hopstop.com)

#### **Women**

##### **Franklin Shelter**

1122 Franklin Avenue (near East 166th Street)  
Bronx, NY 10456  
Telephone 718-842-9827  
Fax 718-842-9820

##### *Directions:*

Subway: Take the 2 train to 149th St., and then the #55 bus to 166th St and 3rd Ave

*Hours:* 24/7

*Area(s) Served:* All Boroughs

*Target Group:* Adult Females 18-65

*ADA Access:* Yes

This is an intake and assessment shelter for single homeless females (NOT pregnant) wanting to enter the city's homeless system. The stay at an assessment shelter can be up to 90 days. During the initial or "intake" period, the homeless individual receives a comprehensive evaluation, including a medical examination, assistance with entitlement applications, if needed; an employment evaluation and, where applicable, a substance abuse and/or psychiatric evaluation. Sometimes, as a result of

these evaluations, an individual may be transferred to a shelter where her particular needs will be addressed. This transfer would take place within a month.

**Families with Children (under 21)**

**PATH (Prevention And Temporary Housing)**

151 East 151<sup>st</sup> Street  
Bronx, New York

*Hours: 24/7*

*Directions:*

Subway: Take the 2, 4, or 5 train to 149th Street/Grand Concourse. Walk north on Grand Concourse two blocks, to E. 151st Street and turn left. Walk two blocks to Walton Avenue.

## II. BRONX HEALTH AND HOUSING CONSORTIUM MEMBERS

### Acacia Network

Housing Category and Quantity	Access Criteria	Application Process	Contact
			<b>Overall</b> James Dike, Director for Outreach 646 242 9563 (cell) <a href="mailto:jdike@promesa.org">jdike@promesa.org</a>
725 DHS Transitional Units for families	Approved by DHS	2010e Categories A, E, F via Jose Correa Program Manager (212) 361-0941 <a href="mailto:jcorrea@dhs.nyc.gov">jcorrea@dhs.nyc.gov</a> Categories D, G via Maria A. Rodriguez Director of Special Projects (212) 607-6085 <a href="mailto:mzrodig@dhs.nyc.gov">mzrodig@dhs.nyc.gov</a>	Robert Gonzalez Program Administrator for Transitional Housing (646) 772-6734 (cell)
600 Transitional Units for singles, including 200 units for people with SPMI	Approved by DHS	DHS referral	Robert Gonzalez Program Administrator for Transitional Housing (646) 772-6734 (cell)
250 Supportive units for singles and families	Approved by HRA	2010e	Kenya Smith Supportive Housing Director (646) 224-0448 <a href="mailto:ksmith@basicsinc.org">ksmith@basicsinc.org</a>
Affordable housing units	Financial criteria	Contact directly	James Dike Director for Outreach (646) 242-9563 (cell) <a href="mailto:jdike@promesa.org">jdike@promesa.org</a>

## **BronxWorks**

### Homeless Outreach Team (HOT)

60 E. Tremont Ave  
Bronx, NY 10453

HOT is a mobile unit that works with homeless individuals on the streets, 24 hours a day, 365 days a year. They help street homeless people get appropriate services and move to safer environments. Their staff also helps place homeless people in permanent or long-term transitional housing.

HOT offers:

- Permanent housing placements
- Referrals to drug and alcohol treatment facilities and emergency shelters
- Counseling
- Benefits assistance
- Crisis intervention (HOT is a certified crisis intervention program)
- Medical and psychiatric services

For more information, please contact:

*Rafael Acevedo, Director*  
[racevedo@bronxworks.org](mailto:racevedo@bronxworks.org)  
(646) 393-4073 (w)

*Alexis Diaz, Clinical Coordinator*  
[adiaz@bronxworks.org](mailto:adiaz@bronxworks.org)  
(646) 393-4074 (w)  
(646) 438-2381 (c)

*Bernice Asamoah, Hospital to Homes Coordinator*  
[basamoah@bronxworks.org](mailto:basamoah@bronxworks.org)  
(718) 893-3606 ext5036(w)  
(646) 531-1786 (c)

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### Living Room / Safe Haven

800 Barretto St.  
Bronx, NY 10474

The Living Room is the only 24-hour drop-in center in the Bronx for street homeless adults. Clients are welcome to spend time off the street, use the laundry and showers, eat a hot meal, receive medical and/or psychiatric services, and get other essential help. They can spend the night in chairs as there are no beds.

Safe Haven is a temporary shelter with 50 beds for homeless adults. The Living Room/Safe Haven offers:

- Housing placement and benefits assistance
- Medical and psychiatric care
- Nutritional assistance
- Medication monitoring
- Substance abuse counseling
- Drug and alcohol treatment referrals

If a client is chronically street homeless for at least one year, a referral for a Safe Haven bed can be made to:

*Cassie Powell*  
Safe Haven Clinical Coordinator  
[cpowell@bronxworks.org](mailto:cpowell@bronxworks.org)  
718-893-3606 x5002

General Contact for the Living Room  
*Noel Concepcion, Residence Director*  
(718) 893-3606  
[nconcepcion@bronxworks.org](mailto:nconcepcion@bronxworks.org)

## BronxWorks Family Shelters and Single Adult Residence

Housing Category and Quantity	Access Criteria	Application Process	Contact
<p><u>BronxWorks</u> Operates three Tier 2 family residences in the Bronx that house a total of 276 homeless families—Nelson (79 units), Willow (102 units) and Jackson (95 units). These residences provide:</p> <ul style="list-style-type: none"> <li>• Private rooms with individual bathrooms and kitchenettes</li> <li>• Help finding permanent housing</li> <li>• Day care and recreation for children</li> <li>• On-site medical care</li> </ul>	<p>At least one adult with at least one child under the age of 21</p>	<p>Via PATH (see page 37)</p>	<p>Nelson Family Shelter Karlene Daly, Residence Director, 718-299-5550 x 301</p> <p>Jackson Family Shelter Wanda Cruz, Residence Director, 718-993-8900 x 235</p> <p>Willow Family Shelter Crosby Inman, Residence Director 718-665-9123 x 225</p>
<p><u>The Brook</u> is located in the South Bronx and has 120 studio units for formerly homeless single adults (many living with mental illness or HIV/AIDS) and 70 units for low-income working adults from the South Bronx. It is owned and operated by Common Ground with support services provided by BronxWorks.</p>	<p>Homeless SPMI – Category A for 120 units for formerly homeless.</p> <p>Income eligibility criteria for 70 low income units.</p>	<p>2010e</p> <p>Online application process from The Brook website</p> <p><a href="http://www.commonground.org/files/Brook_application_April2012.pdf">http://www.commonground.org/files/Brook_application_April2012.pdf</a></p>	<p>Megan Fogarty, Program Director <a href="mailto:mfogarty@bronxworks.org">mfogarty@bronxworks.org</a> (requires javascript) (646) 731-3400</p>

## CitiWide Harm Reduction

Housing Category and Quantity	Access Criteria	Application Process	Contact
<p><u>Drop In Center</u>--226 East 144th Street, contains a tranquil drop-in area, restrooms, shower, laundry, Internet access with computers, group training rooms, a modern serving/teaching kitchen and a vintage café. This is available Monday-Friday 9 am-7:30 pm and Saturday-Sunday 10 am – 6 pm.</p>	<p>Services available to active adult drug users, people living with and at risk for HIV/AIDS.</p>	<p>None necessary</p>	<p>Julie Pena, MSW            Director of Human Services            (718) 292-7718 ext. 225            Robert Cordero, Director  <a href="mailto:jpena@citiwidehr.org">jpena@citiwidehr.org</a></p>
<p><u>Housing placement services</u> for up to 170 people with HIV/AIDS per year for permanent housing through HASA.</p>	<p>Must have diagnosis of HIV/AIDS</p>	<p>Apply to CitiWide directly</p>	<p>Julie Pena, MSW            Director of Human Services            (718) 292-7718 ext. 225            Robert Cordero, Director  <a href="mailto:jpena@citiwidehr.org">jpena@citiwidehr.org</a></p>
<p>There will be a shelter built on site in 2014.</p>			<p>Robert Cordero, Director  <a href="mailto:rcordero@citiwidehr.org">rcordero@citiwidehr.org</a>            718-292-7718 x226</p>



**Comunilife, Inc**

<b>Housing Category and Quantity</b>	<b>Access Criteria</b>	<b>Application Process</b>	<b>Contact</b>
Variety of housing in the Bronx, including OMH supportive, low income and HASA housing for singles and families.	Varies, see below		Rosa Cifre Senior VP for Programs (718) 617-1987 x7141 <a href="mailto:rcifre@comunilife.org">rcifre@comunilife.org</a>
<p>OMH Supportive Housing— all individual rooms.</p> <p>150 Units for adults with serious and persistent mental illness and</p> <p>20 units reserved for adults with serious and persistent mental illness referred from adult home.</p> <p>15 beds for NYNYIII</p> <p>5 beds</p>	<p>Diagnosis of serious mental illness and 2010e approval by HRA for community care, with 20 units referred by adult homes.</p> <p>Category A</p> <p>Category B</p>	2010e	<p>Pamela Timmins Assistant VP for Programs (718) 617-1987 x7178 <a href="mailto:ptimmins@comunilife.org">ptimmins@comunilife.org</a></p>
<p>Low Income Housing</p> <p>121 units for low income singles-studio apts</p> <p>121 units for low income families-2 &amp; 3 bedrooms apts</p>	Must meet HDC income requirements	Apply directly to Fordham Bedford Management company – must meet income requirements, credit check, etc.	Josephine Vega Fordham Bedford Management Company (718) 367-3200
<p>HASA Housing</p> <p>219 units for singles</p> <p>61 units for families</p>	Head of household must have positive HIV/AIDS diagnosis	Application 2010e via HASA	Ketsy Rosado Assistant Program Director (718) 617-1987 x7112

**Comunilife, Inc. (continued)**

<p>Dona Rosita 1 Housing</p> <p>Congregate care housing 40 studio apartments for people with HIV/AIDs</p>	<p>Meet HPD and section 8 criteria</p>	<p>2010e via HASA</p>	<p>Ms. Johnson (718) 585-8669</p>
<p>Prospect Residence</p> <p>Congregate care mixed population for seniors</p> <p>35 units for HASA clients that are NYNYIII</p> <p>25 units for seniors (age 62+) from the community</p>	<p>Section 8 HPD criteria</p> <p>Meet NYNYIII criteria also</p>	<p>2010e through HASA</p> <p>Apply directly with facility</p>	<p>Sandra Griffin (718) 772-0800</p>

**FEGS**

<b>Housing Category and Quantity</b>	<b>Access Criteria</b>	<b>Application Process</b>	<b>Contact</b>
23 units of supportive housing	NYNYIII Category B	2010e	Joanne Heckmann Director, Central Intake (212) 831-7007 <a href="mailto:jheckmann@fegs.org">jheckmann@fegs.org</a>
140 units of OMH certified housing for people diagnosed as seriously mentally ill.	Some units for homeless, HUD eligible.	2010e, after approval by HRA use SPOA for referral. Then mail information with SPOA cover sheet to FEGS.	Joanne Heckmann Director, Central Intake (212) 831-7007 <a href="mailto:jheckmann@fegs.org">jheckmann@fegs.org</a>
34 units of supportive housing.	Mentally ill and approved to function at community care level.	HRA 2010e, must have community care housing approval	Joanne Heckmann Director, Central Intake (212) 831-7007 <a href="mailto:jheckmann@fegs.org">jheckmann@fegs.org</a>

## Jericho Project

Housing Category and Quantity	Access Criteria	Application Process	Contact
<p>78 unit SRO supportive housing for single people with substance abuse history and currently clean and people living in the Community Board 5 area.</p> <p>On site services include case managers, counselors, computer rooms, group courses and skills development.</p>	<p>NYNYI and NYNYII with MICA or DHS referral from general population.</p> <p>Community beds for people living in Community Board 5 with low income and at risk of homelessness.</p>	<p>Requires DHS housing package (can be 2010e for some applicants)</p> <p>Separate application process.</p>	<p>John Snider (718) 538-5494 x311 <a href="mailto:jsnider@jerichoproject.org">jsnider@jerichoproject.org</a></p>
<p>52 unit supportive housing for single people usually from a DHS shelter. There are shared bathrooms and kitchens at this facility.</p> <p>On site services include case managers, counselors, computer rooms, group courses and skills development.</p>	<p>No NYNYIII, only DHS general population referrals. Usually referred by a DHS shelter.</p>	<p>DHS housing package done in shelter.</p>	<p>John Snider (718) 538-5494 x311 <a href="mailto:jsnider@jerichoproject.org">jsnider@jerichoproject.org</a></p>
<p>66 unit supportive housing for single people. Shared bathrooms and kitchens.</p> <p>On site services include case managers, counselors, computer rooms, group courses and skills development.</p>	<p>Multiple sources of funding and applications. HUD units require documented homelessness prior to substance abuse treatment and at risk for homelessness without this program.</p> <p>Some units are set aside for Community Board 5 residents with low income at risk of homelessness.</p> <p>Some units are for people in DHS shelters.</p>	<p>For HUD units, requires Section 8 application, for community units, requires income, residence and homeless potential in application and for DHS general units, requires DHS package usually completed at the shelter.</p>	<p>John Snider (718) 538-5494 x311 <a href="mailto:jsnider@jerichoproject.org">jsnider@jerichoproject.org</a></p>

## Jericho Project

<p>56 SRO supportive housing studios for homeless veterans. Some via the shelter system and others from the local community.</p> <p>On site services include case managers, counselors, computer rooms, group courses and skills development.</p> <p>Another 75 unit supportive housing building is currently under construction.</p>	<p>Veterans may be eligible through NYNYIII category F. They may come from the DHS shelters or the local community Board 5 area.</p>	<p>2010e for NYNYIII</p> <p>Local application for others.</p>	<p>John Snider (718) 538-5494 x311 <a href="mailto:jsnider@jerichoproject.org">jsnider@jerichoproject.org</a></p>
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**Narco Freedom Inc.**

Housing Category and Quantity	Access Criteria	Application Process	Contact
<p>Transitional Sober Housing</p> <p>There are 8 buildings in the Bronx—2 for women and 6 for men, for a total of 520 beds. Each room has 2-4 people.</p>	<p>Transitional sober housing is provided to people who are currently participating in the Narco substance abuse treatment program (not MICA). Participants have substance abuse issues and may also have mental health or other conditions. The substance abuse treatment program includes MMTP, Methadone To Abstinence, Chemical dependency.</p> <p>The program and associated housing is usually available for 6-9 months. Only people who participate in the Narco Substance Abuse Program are eligible.</p> <p>Must be Medicaid or Medicaid Pending.</p>	<p>Call Wayne Clark directly.</p> <p>Otherwise, call the intake process number.</p>	<p>Wayne Clark, Director of Outreach Services and Community Supervision (646) 316-3265 (cell)  <a href="mailto:Wayne.clark@narcofreedom.com">Wayne.clark@narcofreedom.com</a></p> <p>Intake process number:  <b>(718) 402-5250</b></p>
<p>Scatter site</p>	<p><b>32 Units</b> available to people eligible for all NYNYIII categories.</p> <p>Must be Medicaid or Medicaid Pending.</p>	<p>2010e</p>	<p>Wayne Clark, Director of Outreach Services and Community Supervision (646) 316-3265 (cell)  <a href="mailto:Wayne.clark@narcofreedom.com">Wayne.clark@narcofreedom.com</a></p>

**Palladia, Inc.**

<b>Housing Category and Quantity</b>	<b>Access Criteria</b>	<b>Application Process</b>	<b>Contact</b>
<p>300 units of permanent supportive housing for individuals and families in congregate and scatter site housing.</p> <p>This includes family congregate housing, single congregate and scatter site housing, housing for singles and families with HIV/AIDS, Frequent Service Enhancement Program (FUSE- frequently in shelters and jail) and SPMI.</p> <p>Tenants receive case managements support services.</p>	<p>NY/NYIII Category G and F.</p> <p>Formally homeless head of household with a disability (substance abuse, mental illness or HIV+) and a documented source of income.</p> <p>Most people meet the HUD definition of homeless and come from the shelter system.</p>	<p>HRA 2010e for NYNYIII</p> <p>HASA for HIV+ via MIIQ</p> <p>DHS referral for non NYNYIII housing</p> <p>Requires a documented source of income</p>	<p>Lana Hallstein, AVP Housing Services <a href="mailto:Lana.hallstein@palladiainc.org">Lana.hallstein@palladiainc.org</a> (212) 979-8800 x255</p>

**Project Renewal, Inc.**

<b>Housing Category and Quantity</b>	<b>Access Criteria</b>	<b>Application Process</b>	<b>Contact</b>
<p>Fletcher House (OMH funded CR/SRO)- 55 units. Services include 24 hour staffing &amp; clinical services, including on site psychiatry, case management, nursing, medications management and visiting psychotherapist services.</p>	<p>Adults with Axis I psychiatric disorders and possible co-occurring substance disorders. Of the 55 units, 42 must be NYNYI or NYNYII eligible. Of these 42, 21 must also be long-term shelter stayers. The remaining 13 units are for applicants from either Bronx Psychiatric Center, Article 28 hospitals, jails/prisons or the Brooklyn Mental Health Court.</p>	<p>2010e and HRA determination letter for all programs.</p>	<p>Peter Bazeley Program Manager LeonaBlanche House and Fletcher House Residence (646) 243-5183 <a href="mailto:Peter.bazeley@projectrenewal.org">Peter.bazeley@projectrenewal.org</a></p>
<p>Renewal House II (OASAS) 25 shared units 50 beds total.</p>	<p>Adult men who are NYNYIII Category F and employed or employable.</p>	<p>2010e and HRA determination letter for all programs.</p>	<p>Dewett Wilson, Program Manager Renewal House II 718 215-4330 <a href="mailto:Dewett.wilson@projectrenewal.org">Dewett.wilson@projectrenewal.org</a></p>
<p>Leona Blanche House- (OMH funded CR/SRO) 53 units. Services include 24 hour staffing and clinical services, including on site psychiatry, case management, nursing and medications management, and visiting psychotherapist services available to residents and to people in the scatter site Bronx Supportive Housing below.</p>	<p>NYNYI or NYNY II eligible, and of the 53 units, 25 must be long term shelter stayers.</p>	<p>2010e and HRA determination letter for all programs.</p>	<p>Peter Bazeley Program Manager LeonaBlanche House and Fletcher House Residence (646) 243-5183 <a href="mailto:Peter.bazeley@projectrenewal.org">Peter.bazeley@projectrenewal.org</a></p>



**Project Renewal, Inc.** (continued)

<p>Bronx Supportive Housing-20 scattered site units, part of the PC Long Stay Initiative. Residents may use the clinical services, including on site psychiatry, case management, nursing /medications management, and visiting psychotherapist services at Leona Blanche House above.</p>	<p>Residents must be from the Bronx, Rockland or Manhattan Psychiatric Centers who have been there for 1+ years or from licensed housing (Level II) programs which will agree to accept long stay applicants from the above psychiatric centers as a "backfill".</p>	<p>2010e and HRA determination letter for all programs.</p>	<p>Jacqueline Slaton Program Director Bronx Supported Housing (718) 617-7442 <a href="mailto:Jacqueline.slayton@projectrenewal.org">Jacqueline.slayton@projectrenewal.org</a></p>
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## Women In Need, Inc.

Women In Need, Inc. (WIN) is a multi-service agency serving the needs of homeless and low-income families in New York City. WIN provides transitional housing for homeless families in six Tier-II shelters, as well as permanent supportive housing for 246 formerly homeless families with special needs. In addition, WIN operates a New York State-licensed outpatient substance abuse treatment program for women - the Women's Centers for Substance Abuse & Wellness in the Bronx. WIN augments these core services with an array of children's services; education and employment services; HIV prevention and education services; domestic violence assessments and referrals; and other services designed to ensure stable housing and families.

<b>Housing Category and Quantity</b>	<b>Access Criteria</b>	<b>Application Process</b>	<b>Contact</b>
Scatter site- 77 units	Female heads of household who meet all of the following criteria: live in a shelter, are survivors of domestic violence (NOVA letter, order of protection, or other documentation required); have custody of minor children; have a mental health diagnosis; and meet HUD's definition of chronically homeless.	Clients referred directly by shelters and do not require 2010e.	Marilyn Laves, LCSW (718) 402-0066 x126 <a href="mailto:mlaves@w-i-n.org">mlaves@w-i-n.org</a>
Scatter site- 30 units	Female heads of household who meet the following criteria: live in a shelter, are in recovery from substance abuse (6 months clean and documented participation in a substance abuse treatment program is required); have custody of minor children; have a mental health diagnosis; and meet HUD's definition of chronically homeless.	Clients referred directly by shelters and do not require 2010e.	Marilyn Laves, LCSW (718) 402-0066 x126 <a href="mailto:mlaves@w-i-n.org">mlaves@w-i-n.org</a>
20 new units (Summer 2012)	Female heads of household who meet the following criteria: live in a shelter, suffer from a substance abuse disorder; have custody of minor children; and meet HUD's definition of chronically homeless. These clients will be immediately linked to our outpatient substance abuse clinic in the Bronx.	These clients will be referred directly by DHS and will require a 2010e form.	Marilyn Laves, LCSW (718) 402-0066 x126 <a href="mailto:mlaves@w-i-n.org">mlaves@w-i-n.org</a>
Transitional 27 Units for Families (32 hotel units)	Approved by DHS	DHS referral	Garraud Etienne (212) 695-4758 <a href="mailto:getienne@w-i-n.org">getienne@w-i-n.org</a>

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**Women In Need, Inc.** (continued)

Outpatient Substance Clinic for Women	Substance abuse/dependence; 18 and up	Call to make an appointment	Audrey Hyde, Clinical Director (718) 402-0066 x111 <a href="mailto:ahyde@w-i-n.org">ahyde@w-i-n.org</a>
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### **III. OTHER KEY RESOURCES**

**These are other available services that may be useful to Bronx homeless residents.**

Several options are available to men who are homeless and apply for services through the intake service at:

#### **Bellevue Men's Shelter MICA TLC**

30th Street Men's Shelter  
New York, NY 10016  
Telephone: (212) 481-4568  
Fax: (212) 481-4556

Bellevue operates the Transitional Living Center (TLC) as a modified Therapeutic Community (TC) named "the Greenhouse". This is a 30-bed self contained six month rehabilitation program for homeless men 18 years or older who are MICA and are willing to accept treatment.

To be eligible for admission the client needs the following:

- 1) Clients must have been in NYC Department of Homeless Services (DHS) system within the past year. Provide the client's "HA number", DOB, and SS#.
- 2) Clients need a current psychiatric evaluation.
- 3) Clients need a current psychosocial evaluation.
- 4) Clients need a current PPD or Chest X-ray.
- 5) Clients need current labwork.

## **The Bowery Mission Transitional Center**

The Bowery Mission Transitional Center is a successful 9 month program designed to transition formerly homeless drug-addicted men to independent living. Residents participate in counseling, addiction treatment, career education and training at an on-site career center. , residents gain work experience both in-house and then off-site. **77 men can participate in the program at one time.** The men live in single-room occupancy units and pay no rent.

Prospective clients **may only be referred through the Department of Homeless Services.**

Prospective clients must obtain a referral from a caseworker and take a TB test. On site, they complete an intake interview, including a program overview, and agree to comply with program guidelines. Clients entering the program must be male, age 18-45, with a minimum of 90 days clean and sober.

Clients must be willing and able to work and must be free from psychiatric conditions.

For more information, contact the **Intake Coordinator at (212) 777-3424.**

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## **The Bowery Mission Discipleship Institute**

At The Bowery Mission Discipleship Institute, 82 men live in a multi-bed dormitory , working to break destructive habits and preparing for lives of wholeness and lasting productivity.:

Services provided include:

- One-on-one and group counseling sessions with counselors who model Godly character
- Addiction recovery and family restoration curricula
- Career Center offering one-on-one tutoring, remedial education and GED preparation, computer skills training, vocational training and job preparation

Residents are expected to participate in the daily tasks of running The Bowery Mission facility and programs, which teach responsibility, accountability, and the joy of giving back.

- Daily worship, prayer and Bible studies that put men in touch with their Creator and God's purpose for their lives.

All applicants will be interviewed by a counselor. Applicants should be prepared to provide general information relating to personal identification, medical, employment, criminal, military, educational, and family history. Along with the requirements for admission, each applicant must:

- Be at least eighteen years of age
- Have a sincere desire to fully participate in the program
- Commit to completing six months in the Discipleship training program
- Inform staff of probation/parole status if applicable
- Inform staff of any present medical conditions
- Be able to speak, read and write English
- Agree to a one week probationary period

For more information, contact the **Intake Coordinator at (212) 674-3456.**

## **Bronx Community Pride Center: Operation Home Base: RHY Drop-In Center**

Information Provided By: LifeNet, A Program Of The Mental Health Association Of New York City

448 East 149th Street  
Bronx, NY 10455  
Telephone: (718) 292-4368  
Fax: (718) 292-4999  
[www.bronxpride.org](http://www.bronxpride.org)

RHY Drop-in Centers are located in each borough. They provide homeless and at risk youth (under age 21) and their families with information and access to a variety of services including: food provision, counseling, mediation, educational assistance and referrals to local resources. There is a licensed Social Worker on staff at each location. This location offers specialized services to gay, lesbian, bisexual, questioning and transgendered youth.

**Hours:** 9am - 9pm

**Area(s) Served:** All Boroughs

**Target Group:** All Youth Child 0-12, Adolescent 13-17

**Fees:** No fee

**ADA Access:** No

**Transportation:**

Subway: Take the 2 or 5 train to 3rd Avenue/149th Street

**Community Access Inc.**

<b>Housing Category and Quantity</b>	<b>Access Criteria</b>	<b>Application Process</b>	<b>Contact</b>
<p>NYNY I &amp; II 369 units OMH certified</p>	<p>history of mental illness &amp;/or those who are homeless, struggling with substance abuse, have been incarcerated, veterans.</p>	<p>We require a 2010e and get referrals from the DHS</p>	<p>Chloe Allen, Property Management Coordinator (212) 780-1400 <a href="mailto:callen@communityaccess.org">callen@communityaccess.org</a></p> <p>Sujel Perez, Intake Supervisor (212) 780-1400 x7741 <a href="mailto:sperez@communityaccess.org">sperez@communityaccess.org</a></p>
<p>OMH Certified 64 units</p>	<p>history of mental illness</p>	<p>2010e</p>	<p>Sujel Perez, Intake Supervisor (212) 780-1400 x7741 <a href="mailto:sperez@communityaccess.org">sperez@communityaccess.org</a></p>
<p>OMH supported (not certified) 55 units</p>	<p>history of mental illness</p>	<p>2010e</p>	<p>Sujel Perez, Intake Supervisor (212) 780-1400 x7741 <a href="mailto:sperez@communityaccess.org">sperez@communityaccess.org</a></p>
<p>low income singles 65 units</p>	<p>Low income</p>	<p>Application to housing management</p>	<p>Chloe Allen Property Management Coordinator (212) 780-1400 <a href="mailto:callen@communityaccess.org">callen@communityaccess.org</a></p>
<p>low income families 65 units</p>	<p>Low income</p>	<p>Application to housing management</p>	<p>Chloe Allen Property Management Coordinator (212) 780-1400 <a href="mailto:callen@communityaccess.org">callen@communityaccess.org</a></p>
<p>supportive SRO 480 units</p>	<p>history of mental illness</p>	<p>2010e</p>	<p>Sujel Perez Intake Supervisor (212) 780-1400 x7741 <a href="mailto:sperez@communityaccess.org">sperez@communityaccess.org</a></p>
<p>CR/SRO Licensed by OMH Extended stay 64 units</p>	<p>A history of mental illness and/or those who are homeless, struggling with substance abuse, have been incarcerated, veterans.</p>	<p>Referrals from state hospitals, shelters and OMH with 2010e.</p>	<p>Sujel Perez Intake Supervisor (212) 780-1400 x7741 <a href="mailto:sperez@communityaccess.org">sperez@communityaccess.org</a></p>

## Homes for the Homeless: Family Support Center

730 Kelly Street

Bronx, NY 10455

Telephone: (718) 617-6100

Fax: (718) 617-0281

[www.theprospectfamilysupportcenter.com](http://www.theprospectfamilysupportcenter.com)

The Family Support Center offers 24 hours temporary emergency childcare to children (newborn - 6 years old) at risk of abuse or neglect. The center offers support, referrals and case management services to families in crisis. For this support, call the number above.

**Alias:** Prospect Family/Respite/Bx

**Hours:** M-F 10am-6pm

**Area(s) Served:** All Boroughs

**Target Group:** All Youth Child 0-12, Adolescent 13-17

**Fees:** No fee

**Accepted Payment:** N/A

**ADA Access:** No

**Transportation:**

Subway: Take the 2, 5, or 6 train to ?

Bus: Take the M4, M17, or M19 to ?



**Queen of Peace**

335 East 145th Street  
Bronx, NY 10451  
Phone: (718) 292-0019  
Fax: (718) 292-2929

*Executive Director: M. Rose Clara*

Beds are available each night on a first come first served basis. Bed assignment begins at 4 PM.

**DESCRIPTION**

The Missionaries of Charity is the congregation of religious sisters founded by Blessed Teresa of Calcutta. They work with drug addicts, homeless men/women, AIDS patients and unwed mothers as well as run a soup kitchens, teach catechism in poor parishes and visit needy families.

**SERVICES PROVIDED**

- Emergency Meals
- Emergency Shelters

**Weston United Bronx Star**

<b>Housing Category and Quantity</b>	<b>Access Criteria</b>	<b>Application Process</b>	<b>Contact</b>
<p>substance abusers in recovery</p> <p>50 beds in 2 and 3 bedroom scatter site units in the North Bronx, with each person having a bedroom.</p> <p>Case management on site and other services are arranged.</p> <p>Usual length of stay 6-9 months.</p>	<p>NYNY III</p> <p>Category F</p> <p>Axis 1 Substance Abuse plus some mental health issues in addition, but not severe mental health issues.</p> <p>All clients need to be clean 6+ months, and willing to attend outpatient or aftercare programs.</p>	<p>2010e</p> <p>2 interviews required</p>	<p>Victor Herbert (646) 794-1499 x2 <a href="mailto:vherbert@westonunited.org">vherbert@westonunited.org</a> Please call if you have a potential referral</p>

## GLOSSARY

TERM	DEFINITION
Apartment Treatment	Apartment Treatment Programs provide transitional housing in the community in shared apartments, which usually house two to four people and are Level II funded facilities certified by the New York State Office of Mental Health.
Certified Residence	Has been issued an operating certificate by a NYS agency such as the Office of Mental Health, Office of Substance Abuse and Alcohol Services, etc. and is approved for Congregate Care Level II enhanced SSI rates
Community Residence (CR)	Supervised Community Residences are congregate care facilities, which house approximately 10 to 24 residents; similar to a group home and are classified as Level II funded facilities and have been issued an operating certificate by a NYS agency. The emphasis of services is on skill building so the residents can move to less restrictive levels of care.
Community Residence Single Room Occupancy (CR/SRO)	CR/SROs are congregate care, Level II facilities certified by the New York State Office of Mental Health.. They are considered “extended stay” housing. In this model, residents typically stay between two and five years before they transition on to a more independent setting. In many respects, CR/SROs are similar to Supported SROs, but have more on-site social service staff.
Emergency housing	Emergency Housing is time limited with lengths of stay ranging form a few days to several months.
Extended Stay	It is not permanent housing but the length of residency does not have strict term limits.
Mentally Ill Chemical Abuser (MICA)	people with co-occurring substance abuse and severe mental illness
NY/NY Housing	Housing units are developed by New York City and New York State under the terms of these agreements focused on housing individuals who are homeless, at risk of homelessness, and have some identified special need.
Permanent Housing	Permanent Housing provides tenants with a lease.
Safe Haven	Safe Haven programs are extended-stay programs. They provide housing for individuals who are homeless and have not successfully engaged in conventional housing or outpatient treatment

<p>Seriously and Persistently Mentally Ill (SPMI)</p>	<p>SPMI is defined by the New York State Office of Mental Health as follows:  The person has a primary mental health diagnosis  The individual is at least 18 years of age  The person must meet one of the following criteria to be considered SPMI:  SSI or SSDI Enrollment due to Mental Illness  Extended Impairment in Functioning due to Mental Illness  Reliance on Psychiatric Treatment, Rehabilitation, and Supports  GAF score must be less than 50</p>
<p>Single Point of Access</p>	<p>The Single Point of Access (SPOA) Housing Program is a housing and data collection project that helps connect specially identified applicants to the most appropriate residences and services.</p>
<p>Special Needs Housing</p>	<p>Special Needs Housing is for specific groups of clients or tenants.</p>
<p>Supportive SRO  aka. Supported SRO</p>	<p>Supportive SROs provide permanent housing in single room occupancy (SRO) buildings. All Supported SROs offer leases to tenants for furnished single rooms that, in most cases, have recently been renovated. In some Supportive SROs, bathrooms and/or kitchens are shared. Newer buildings offer “efficiency studios” with private bath and kitchenettes. Most Supportive SROs are run by a nonprofit organization and receive funding for services from multiple sources, including the NYC Department of Health and Mental Hygiene (DOHMH), the NYC Department of Homeless Services (DHS), and/or the HIV/AIDS Services Administration (HASA).</p>
<p>Tax Credits</p>	<p>This act provides an incentive for home developers to build, buy and refurbish housing for low-income taxpayers. The Low-Income Housing Tax Credit also provides a non-refundable credit for those who invest in low-income housing projects as a means of stimulating the flow of capital into this sector. The type of housing structures typically used for this credit are multi-family dwellings.</p> <p>The Low-Income Housing Tax Credit was created as part of the Tax Reform Act of 1986. Residents of these housing projects cannot have incomes that exceed certain guidelines in order for the project to qualify for the credit.</p>
<p>Transitional Housing</p>	<p>Transitional Housing provides residents with a residency agreement that includes tenant rights and responsibilities such as paying fees and complying with individual service plan and it also defines the program operator’s responsibilities; it is not a lease. Transitional Housing frequently has program participation requirements for residents.</p>