# Chapter 6: Housing Resources for ALTSA Clients

Chapter 6 describes Housing Resources available only to clients who are on ALTSA services. These resources are available to clients depending on individual housing resource eligibility criteria.

#### *Ask the Expert*

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## 6.1 Background

The ALTSA Housing Team’s mission is to increase access to permanent and affordable housing for ALTSA clients and ensure the availability and consistent utilization of services that support tenancy in independent housing. Our work centers on the following beliefs and values:

* Affordable housing is the foundation for stability and growth.
* Housing improves health.
* Income, age, ability, lack of family and friends, or past or current conduct should not prevent anyone from having a home.
* Each tenant holds their lease or mortgage and is responsible for maintaining tenancy.

The ALTSA Housing Team brings together federal, state, and local resources to create opportunities and strategies to help our clients find and afford independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance about vouchers and subsidies the ALTSA Housing Team can help you access, and describes services, such as Supportive Housing and long-term care services available to ALTSA clients in support of their tenancy. Whenever possible, we offer guidance about difficult situations you might encounter, including tips about working with clients experiencing homelessness. Affordable housing and tenancy supports are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like the see addressed in this chapter.

## [6.2](#_Background) Permanent Federal HUD Vouchers

Starting in 2011, the ALTSA Housing Team began collaborating with local Public Housing Authorities (PHAs) to make Housing Choice Vouchers (HCVs) available to DSHS clients. For background, the Housing and Urban Development (HUD) agency awards these vouchers (formerly known as Section 8) to the PHAs through a competitive process called “Notice of Funding Allocations” (or NOFAs). The voucher pays for a portion of the individual's rent and the individual is responsible for paying 30% of their monthly household toward rent.

The different types of HCVs the ALTSA Housing Team administers are the Non-Elderly Disabled (NED1, NED2, Mainstream Voucher [MSV]) and the Referral Voucher Program (RVP). Your regional ALTSA Housing Program Manager can help you understand the eligibility criteria for these vouchers and let you know where there is current availability.

**What is a “Non-Elderly Disabled” (NED) voucher?**

HUD defines a “Non-Elderly Disabled Family” as a family whose head of household, or sole member, is 18-61 years of age at the time of lease signing, and the qualifying person has a disability. There are three subcategories of NED vouchers that target specific groups of people with disabilities:

* **NED Category 1** vouchers are available to the qualifying person (and their family, if applicable) regardless of their current living situation.
* **NED Category 2** vouchers are available to the qualifying person (and their family, if applicable) who is currently living in an institutional setting such as Skilled Nursing Facilities, hospitals,Residential Habilitation Centers for individuals with developmental disabilities, and Psychiatric Hospitals (Eastern and Western State). The institutional settings, though, **exclude** board and care facilities (e.g., adult homes, adult day care, adult congregate living), residential services, and community-based congregate settings. Prison is also excluded.
* **NED Mainstream** vouchers (MSV)are available to the qualifying person (and their family, if applicable) who are institutionalized (see definition above), or at risk of institutionalization, or homeless, or at risk of homelessness. Please ask your regional Housing Program Manager for more information on what are the definitions of *at risk* and *homeless*, as these may vary depending on the PHA.

**What Is the Referral Voucher Program (RVP)?**

The RVPis a Housing Choice Voucher (HCV) and is not considered a NED voucher. It is available to individuals regardless of setting who are receiving ALTSA LTSS. There is a service component for this voucher and applicants should be agreeable to receiving LTSS. This voucher is available to applicants over the age of 18.

**Where are permanent HUD vouchers available?**

* Region 1:
* City of Yakima: NED2 and MSV
* Spokane, Ferry, Stevens, Pend Oreille, Lincoln, and Whitman Counties: NED 1 and Mainstream and RVP
* City of Kennewick: NED1 and MSV
* Okanogan County: MSV
* Region 2:
* Snohomish County: NED2
* Whatcom County: RVP
* Region 3:
* City of Tacoma/Pierce County: NED2 and MSV
* Jefferson and Clallam Counties: NED2
* Cowlitz, Lewis, Pacific and Wahkiakum Counties: NED2

**Does an individual have to reside in the area where the voucher is available?**

The current location of a client is not a barrier to applying for federal vouchers. Public Housing Authorities (PHAs) allow anyone to apply for vouchers or public housing, and eligibility is not based on the current location or residence of the applicant. Applicants currently living within the service area of the PHA, however, may be given preference.

**What are the basic eligibility requirements for permanent HUD vouchers?**

A household must:

* Be very low-income. A household’s income must be at, or below, 50 percent of the Area Median Income as determined by HUD. Each year, HUD publishes these income limits for every housing market across the nation:

<https://www.huduser.gov/portal/datasets/il.html>

* Be a citizen or a non-citizen with “eligible immigration status,” and
* Be in good standing with federal housing programs. Specifically, a household must not have:
  + Been evicted from federally assisted housing for illegal drug activity within the past 3 years.
  + Be required to register as a lifetime sex offender.
  + Been convicted of producing methamphetamine in federally assisted housing.
* A criminal history may disqualify an applicant from the voucher. On a case-by-case basis, a denial can be appealed except for the above three categories.

**What are the roles and responsibilities in the eligibility process?**

There is a multi-level process for determining eligibility for and processing of permanent HUD vouchers. ALTSA, contracted providers and Housing Authorities all have a role in the process.

* **ALTSA Housing Program Managers (HPMs):** Are responsible for screening and referring applicants from case managers that expressed their client’s need for affordable housing. All referrals are made through ALTSA Housing Program Managers to Public Housing Authorities; individuals contacting Public Housing Authorities outside of this process will be directed to ALTSA Housing Program Managers.
* **HCS Case Managers:** Make referrals for ALTSA housing resources, create transition plans, and authorize transition goods and services.
* **Contracted Providers** (Community Choice Guides or Supportive Housing Providers): Complete tasks and purchases authorized by the HCS Case Manager to support the client in reaching transition and/or stabilization goals.

**Public Housing Authorities:** After receiving the initial application packet from ALTSA, they will screen the applicants on their prior tenant history, conduct criminal background checks, rental history, and credit history checks, and screen for other criteria. Each PHA is then responsible for administering their program in accordance with their housing plan. **What is the process to refer a client for permanent HUD vouchers?**

* **Contact your** [**Regional ALTSA Housing Program Manager**](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA-Housing-Regional-Map.pdf) **(HPM) with the client’s name and ACES ID**
  + HPM will prescreen the client and determine if the client is eligible to apply.
  + If client is found eligible, HPM will email the housing application to the NFCM and cc supervisor.
  + This is the time to make a CCG referral -- if one hasn’t been made yet.
* **Complete the application and provide supporting documentation**
  + If the client needs support completing the application and gathering documents, this can be provided by the NFCM, SNF Social Worker, or contracted provider.
* **Submit completed application to HPM**
  + HPM will review the documents and submit to the PHA.
  + PHAs will schedule briefing appointment with client and/or contact.
* **HPM will work with contracted provider and PHA on housing search and lease up process.**
* **Clients must remain in the SNF until the voucher is issued by the PHA. Once client has signed the lease, a transition date can be set, and client can move.**

**What is the required documentation for my client to apply?**

Depending on the PHA, the required application materials can vary. However, the following is a list of common items required. Ask your Regional Housing Program Manager about the specific documents required for your client’s application:

* Current state issued photo ID. PHAs will not accept expired ID.
* Copies of Social Security card(s).
* Copies of current year Social Security award letters or other first-party income verification. In some circumstances, HPM may be able to provide income verification via ACES.
* Copies of bank statements if clients have checking or savings accounts.
* Disability verification if client is not receiving income based on their disability.

**How will I know if there are permanent HUD vouchers available?**

At times, there may be immediate availability of vouchers, and when those situations arise, the announcements about openings are distributed statewide via regular emails to HCS supervisors, Program Managers and RCL Specialists so the information can be dispersed to HCS Case Managers.

**Is there a waitlist for permanent HUD vouchers?**

Regional HPMs maintain short waitlists of eligible applicants. When there are enough applicants on a waitlist, the HPM will no longer accept additional applications. Because the turnover in vouchers is not predictable, the HPMs will not be able to predict how long a person may need to wait for an available voucher.

## 6.3 811 Units: Project BASED Rental Assistance (PRA)

Funding for the 811 Project Based Rental Assistance (PRA) apartment units were created by a grant from HUD. The grant provides project-based subsidies for newly built or converted housing units statewide, providing an increase in the number of permanent, affordable housing units for non-elderly clients with disabilities. HUD administers this grant through the Washington State Department of Commerce, which partners with DSHS-ALTSA to make referrals to the units and coordinate services for residents.

**What is the definition of an “811 PRA unit”?**

An 811 Project Based Rental Assistance (PRA) unit is created through a contract between the Washington State Department of Commerce and a housing provider. The subsidy is paid to the housing provider and cannot be transferred to another apartment or otherwise follow a client when they move. When a client moves from an 811 unit, the rental assistance does not move with them to the new location. The 811 PRA units are permanent housing, and tenants may live there if they continue to meet the annual eligibility criteria and remain in compliance with their lease agreement.

**What locations in Washington State have 811 PRA units?**

The following areas have 811 units:

* Region 1:
* Spokane County: Spokane and Spokane Valley
* Chelan County: Wenatchee
* Benton County: Kennewick and Richland
* Franklin County: Pasco
* Region 2:
* King County: Seattle, Renton and Auburn
* Region 3:
* Thurston County: Olympia
* Clark County: Vancouver
* Clallam County: Port Angeles

**Does an individual have to live in the city or county where the 811 PRA unit is located?**

The current location of a client is not a barrier to applying to any of the properties that have 811 PRA units. Property managers allow eligible applicants to apply for available units regardless of an applicant’s current location or residence.

**What are the basic eligibility standards for 811 PRA units?**

A household must:

* Be extremely low-income. A household’s income must be at or below 30 percent of the area-wide median income as determined by HUD. Each year, HUD publishes these income limits for every housing market across the nation: <https://www.huduser.gov/portal/datasets/il.html>
* Applicant must be between the ages of 18-61 at the time of lease signing.
* Be a citizen or a non-citizen with “eligible immigration status,” and
* Be in good standing with federal housing programs. Specifically, a household must not have:
  + Been evicted from federally assisted housing for illegal drug activity within 3 years.
  + Been required to register as a sex offender.
  + A felony conviction for the manufacturing or production of methamphetamine.
* A criminal history may disqualify an applicant from an 811 unit. Denials can be appealed on a case-by-case basis except for the above three categories.
* Applicant must be active on a DSHS caseload upon move into the unit but are not required to maintain LTSS to retain the housing.

**What settings do people need to be transitioning from to be eligible for 811 PRA units?**

The 811 program follows an eligibility priority:

* 1st priority: People living in institutional settings and those that are homeless.
* 2nd priority: Individuals wishing to move from residential settings.
* 3rd priority: In-home clients needing other housing due to safety, accessibility or rent burden issue/s.

The Housing Program Managers will process 811 client applications in the order received, and when there are multiple applications for limited units, the above priorities will apply.

**What are ALTSA’s and the Property Management agency’s responsibilities in the 811 PRA units’ eligibility process?**

There is a multi-level process for determining eligibility for 811 units. Both ALTSA and Property Managers are responsible for determining client eligibility. Due to the complex funding strategies used to create the tax credit properties that 811 units are in, eligibility criteria may also vary by property.

* **ALTSA Housing Program Managers:** Are responsible for screening and referring applicants from case managers who expressed their client’s need for affordable housing. All referrals are made through ALTSA Housing Program Managers to 811 Property Managers; individuals contacting these agencies outside of this process will be directed to ALTSA Housing Program Managers.
* **HCS Case Managers:** Make referrals for ALTSA housing resources, create transition plans, and authorize transition goods and services.
* **Contracted Providers** (Community Choice Guides or Supportive Housing Providers): Complete tasks and purchases authorized by the HCS Case Manager to support the client in reaching transition and/or stabilization goals.
* **Property Management Agencies**: After receiving initial application packets from ALTSA, Property Managers will screen the applicants on their prior tenant history, conduct criminal background checks, rental history, and credit history checks, and screen for other criteria. Each agency is then responsible for administering the 811 program in accordance with its tenant selection plan.

**How do I make a client referral for an 811 unit?**

* **Contact your** [**Regional ALTSA Housing Program Manager**](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA-Housing-Regional-Map.pdf) **(HPM) with the client’s name and ACES ID**.
  + HPM will prescreen the client and determine if the client is eligible to apply.
  + If client is found eligible, HPM will email the housing application to the NFCM and cc Supervisor.
  + This is the time to make a CCG referral -- if one hasn’t been made yet.
* **Complete the application and provide supporting documentation.**
  + If the client needs support completing the application and gathering documents, this can be provided by the HCS CM, AAA CM, SNF Social Worker, or contracted provider.
* **Submit completed application to HPM.**
  + HPM will review the documents and submit to the Property Manager.
  + Property Managers will schedule briefing appointment with client and/or contact. Once client has signed the lease, a move-in date can be set and client can move.

**What is the required documentation for my client to apply?**

Depending on the Property Management agency, the required application materials can vary. However, the following is a list of commonly items required. Ask your regional HPM for specific documents required for your client’s application:

* Current state-issued photo ID. Expired ID will not be accepted.
* Copies of Social Security Card(s)
* Copies of current years Social Security award letters or other first party income verification

**How will I know when there is an 811 unit available?**

At times, there may be immediate 811-unit availability, and when those situations arise, the openings will be announced to the field via email notifications.

**Is there a waitlist for 811 units?**

Regional HPMs maintain short waitlists of eligible applicants. When there are enough applicants on a waitlist, the HPM will no longer accept additional applications. Because the turnover in 811 PRA units is not predictable, the HPMs will not be able to predict how long a person may need to wait for an available 811 PRA unit.

## [6.4](#_Background) ALTSA Bridge, ALTSA Acute Care Hospital, and GOSH State Subsidies

## The ALTSA Bridge subsidy program was launched in 2012 as a part of the Roads to Community Living Demonstration program. Bridge rental subsidies are intended to support individuals moving from institutional to community settings.

The **ALTSA Acute Care Hospital** subsidy was launched in 2024 to help discharge individuals in Acute Care Hospitals where housing is barrier.

## The ALTSA GOSH subsidy is available as part of the larger Governor’s Opportunity for Supportive Housing (GOSH) program for individuals discharging or diverting from Western State Hospital or Eastern State Hospital. The GOSH subsidy is paired with Supportive Housing services that assist the person with their transition back to the community and remains with the person if they are eligible.

ALTSA contracts with the Spokane Housing Authority (SHA) to issue, track, and monitor these subsidy payments throughout all of Washington State to housing providers to help streamline the program.

[Video: ALTSA Subsidy Training Overview](https://www.youtube.com/watch?v=hI8j4dN4_TI)

**What is the goal of ALTSA subsidies?**

ALTSA subsidies provide rental assistance for eligible ALTSA clients in the form of a monthly rent subsidy that is paid directly to housing providers, like tenant-based housing choice vouchers. The client is responsible for a portion of the rent, paid directly to the landlord, calculated at approximately 30 percent of the household’s total income.

ALTSA subsidies are intended to assist clients in transitioning into affordable housing while they remain on waitlists for permanent, affordable housing.

**What is Global Leasing?**

Global Leasing is an ALTSA program centered on Housing First that aims to quickly lease up referred clients who face high housing barriers. It braids ALTSA Long-Term Services & Supports (LTSS) and housing resources with risk mitigation funds as an added layer of security for both landlords and lease holders while offering housing options for clients.

**Where in Washington State are ALTSA subsidies available?**

ALTSA subsidies are available statewide. The Spokane Housing Authority is contracted to administer the subsidy on behalf of ALTSA, but clients may live in any area of the state.

**What are the basic eligibility standards for ALTSA subsidies?**

There are three eligibility tracks for an ALTSA subsidy:

* 1. **ALTSA Bridge**: Clients exiting from a Skilled Nursing Facility who will transition to the community on In Home services.
  2. [**ALTSA Acute Care Hospital**: Clients discharging from the Acute Care Hospitals where housing is a barrier.](#AcuteCareHospital)

**3. ALTSA GOSH**:  Clients exiting or diverting from Eastern or Western State Hospitals. The ALTSA GOSH subsidies are a part of the larger GOSH service that includes Supportive Housing services. Please see [Section 6.5](#_5B.5_Governor’s_Opportunity) for more in-depth information on the GOSH service and how to make a referral.

To receive the ALTSA Bridge or GOSH subsidy, an individual must sign the [ALTSA Subsidy Participant Agreement.](#_Forms:) Click here for more information about [ALTSA Subsidy Policies and Procedures and client document Tips for Maintaining LTSS.](#_Forms:)

**What are Spokane Housing Authority’s and ALTSA’s responsibilities in determining eligibility for the ALTSA subsidy?**

Both ALTSA HPMs and the Spokane Housing Authority play a role in determining eligibility for the ALTSA subsidy.

**ALTSA Housing Program Managers:**

Are responsible for screening and referring eligible ALTSA subsidy applicants to the Spokane Housing Authority. Individuals that contact the Spokane Housing Authority outside of this process will be directed to ALTSA Housing Program Managers.

**Spokane Housing Authority (SHA):**

After receiving initial application packets from ALTSA, SHA will process subsidy applications and manage the subsidy process statewide for ALTSA. SHA communicates with landlords for inspections, provides documents needed during the lease-up process, and calculates the monthly ALTSA subsidy amount to be paid to the landlord, and communicates with client.

**How do I make a referral for a client who I believe is eligible for an ALTSA subsidy?**

For **ALTSA Bridge subsidy referrals**, contact your [Regional Housing Program Manager](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA-Housing-Regional-Map.pdf) with the client’s name and ACES ID or complete a [Bridge Subsidy Referral Form](#_Forms:) and send it to your regional HPM. Please also see the [Bridge Referral and Application Process form](#_Forms:). An individual needs to have been determined both functionally and financially eligible through an assessment to receive the ALTSA subsidy.

HPMs will screen your client by looking in CARE to determine setting and eligibility. If clients are financially eligible for ALTSA services, then they are financially eligible to receive the subsidy. If your client is eligible to apply, the HPM will send you the application.

For **ALTSA Acute Care Hospital subsidy referrals,** completely fill out [ALTSA Subsidy- Acute Care Hospital Referral Form](https://stateofwa.sharepoint.com/sites/DSHS-ALT-HCSHousingTeam/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FDSHS%2DALT%2DHCSHousingTeam%2FShared%20Documents%2FGeneral%2FALTSA%20Subsidy%2FHospital%20Vouchers%2FForms%2FALTSA%20Subsidy%2DHospital%20Referral%20Form%5F10%2D2024%2Epdf&parent=%2Fsites%2FDSHS%2DALT%2DHCSHousingTeam%2FShared%20Documents%2FGeneral%2FALTSA%20Subsidy%2FHospital%20Vouchers%2FForms) and submit to email [hospitalsubsidy@dshs.wa.gov](mailto:hospitalsubsidy@dshs.wa.gov). A regional Program Manager will follow up and provide the application if client is determined to be eligible for the ALTSA Subsidy.  An individual needs to have been determined both functionally and financially eligible through an assessment to receive the ALTSA Acute Care Hospital subsidy, and client is currently in an Acute Care Hospital when referred to the subsidy and while application is received, processed, and housing search packet is then issued. Clients may choose to work with a Community Choice Guide or if client desires ongoing housing supports, a Supportive Housing Provider can be assigned. **Please Note:** Client cannot discharge before a provider is authorized and application fully processed. **This can take up to 10 days.**

For information regarding the **ALTSA** **GOSH subsidy**, contact your [GOSH Supportive Housing Program Manager](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA-Housing-Regional-Map.pdf).

**What is the documentation required for my client to apply?**

The ALTSA subsidy is a low-barrier application. Below is a list of documentation to include with the application:

* Current state-issued photo ID
* Copies of Social Security card
* If available: copies of current year’s Social Security award letter or other first party income verification. If not, HPM can provide an income verification letter for the application.

Please reach out to the HPM if your client does not have the above documentation. Clients should be actively working on obtaining the above documents as they will be needed to apply for units where the subsidy will be used.

**How will I know when there are ALTSA subsidies are available?**

Based on the funding availability for the ALTSA Bridge subsidy, openings will be announced via NFCM Workspace emails monthly. [Regional Housing Program Managers](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA-Housing-Regional-Map.pdf) can also be contacted for availability.

ALTSA Acute Care Hospital Subsidies are limited. Please reach out to [hospitalsubsidy@dshs.wa.gov](mailto:hospitalsubsidy@dshs.wa.gov) for availability.

ALTSA GOSH Subsidies are regularly available to clients who are accepted to the GOSH program.

**Attention:** there is a waitlist for the **Bridge Subsidy**.  When a referral is made and approved, the client will be placed on the waitlist.  The client must remain in the Skilled Nursing Facility (SNF) and be financially and functionally eligible for LTSS when they reach the top of the list.  At this point, the Housing Program Manager (HPM) will reach out to the CM to provide the application, which is the next step to getting a voucher issued.

**Is there a waitlist for ALTSA subsidies?**

Currently there is a waitlist maintained for ALTSA Bridge subsidies as they are limited by funding availability. Referrals and applications are only accepted when funding is available. Please check in with your regional HPM for availability.

ALTSA Acute Care Hospital Subsidies are limited, with only 40 available currently. There is no waitlist.   
  
ALTSA GOSH Subsidies are regularly available to clients who are accepted to the GOSH program. There is no waitlist for the ALTSA GOSH Subsidy.

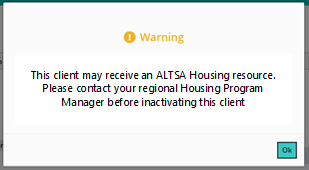
**How do I document the ALTSA subsidy in CARE?**

The HCS CM must enter the following into the CARE assessment:

* + Add “Housing subsidy (HCS/AAA)” as a Treatment for ALTSA Bridge and ALTSA GOSH subsidy recipients.
    - On the Medical Screen in CARE, choose the Program “Housing Subsidy (HCS/AAA)”
    - Check “No” for Received in the Last 14 days?
    - Check “Yes” for Need
    - Choose “Agency” for the Provider
    - Choose “PRN” for Frequency
    - For Comments, type: “*Client will be receiving the ALTSA Housing Subsidy administered by Spokane Housing Authority.”*
  + Add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of “Housing subsidy (HCS/AAA)”.

The Housing Subsidy treatment identifies a client who is receiving the ALTSA rental subsidy. This subsidy is paid for and managed by ALTSA and should be added when an individual receives the subsidy. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.

When "Housing Subsidy (HCS/AAA)" is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:



This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.

Additionally, the CM must:

* Add ALTSA Housing Program Manager as a collateral contact.
* SERs regarding housing should be entered using *Housing* purpose code.

After transition, the client’s file is typically transferred from HCS to the local AAA office. For clients utilizing the ALTSA Bridge subsidy, the AAA CM will be notified by the HPM that their client is receiving an ALTSA Bridge subsidy and will be informed on how the subsidy will be maintained.

An initial email from the HPM to the AAA CM is sent, introducing themselves as the ALTSA Bridge subsidy contact. This email will also share information and expectations about working with a client who has an ALTSA Bridge subsidy. The email will include information on:

* The expectation of supporting the client’s tenancy through utilizing Community Transition Services or Foundational Community Supports - Supportive Housing program.
* Assisting the HPM with the annual subsidy recertification process.

**What is needed to transfer an ALTSA subsidy client from HCS to the AAA?**

* Please see [Section 9 in this chapter *Pairing Services with Housing Resources*](#_5B.8_Community_resources)*.*
* Clients should transition from institutional settings to independent housing with an open Community Choice Guide authorization for the client’s continued utilization as needed once the case is transferred to the AAA. An exception to this would be if a client has been referred to FCS Supportive Housing or GOSH services. However, clients can still access other goods and services through Community Transition Services as needed.

**How do CM’s assist in maintaining the ALTSA Subsidy?**

* For Bridge recipients, HPMs typically utilize CARE to verify the client is still residing in their unit. However, the HPM may reach out to the CM and may ask for assistance in contacting the client when needed.
* CMs can utilize GOSH Supportive Housing Providers (SHPs) to assist with the recertification for GOSH clients. CMs can also authorize a Community Choice Guide (CCG) or Foundational Community Supports - Supportive Housing Provider to assist Bridge clients with this task.
* ALTSA Subsidy clients are required to complete an annual recertification to maintain their subsidy. It is a simple packet, mostly requiring client signatures. The process is as follows:

1. The HPM will send CM recertification documents, along with a cover letter that indicates to the client a return due date.
2. The CM will send documents to client and collect them back with signatures.
3. CM will scan and send the completed documents back to the HPM.
4. If the CM is unable to connect with the client, HPM must be informed prior to the due date on the cover letter. HPM may ask that a CCG be authorized to assist with the task.

**Note:** When an ALTSA client is already enrolled in a housing service (GOSH, MIST, housing voucher) and any type of assessment (Initial, Annual, Interim, or Significant Change) is conducted with the client, and there is a possibility client is no longer functionally eligible for LTC services, HCS/AAA CM will review the assessment with the client prior to scheduling a staffing with SHPM, and before moving the assessment to current/history. A SER note is required for the assessment review with the client.

**How are the ALTSA subsidy payments made?**

The ALTSA subsidy rent payments are made utilizing a process between ALTSA HQ and Spokane Housing Authority (SHA). ProviderOne is no longer utilized to make rent payments to SHA.

**“May a client be absent from the unit for an extended period?”**

Yes, a client with a subsidy may be out of the unit and retain the subsidy in the following situations: When a client is absent from their unit for health-related reasons or incarcerated, ALTSA will pay the subsidy for up to 6 months (180 days).

## [6.5](#_Background) Working with individuals on altsa housing resources who are not currently receiving altsa ltss

**How can ALTSA assist individuals who are no longer receiving LTSS?**

Individuals who are residing in subsidized housing that was coordinated through ALTSA, whether through the state-funded ALTSA Subsidy or a federal voucher through HUD (NED/MSV/RVP and 811 vouchers), are eligible for WA Roads regardless of whether the client is currently eligible for, or receiving, State Plan or Waiver HCBS. This section is specific to individuals who are stably housed with an ALTSA Subsidy or a federal voucher that was coordinated through ALTSA. This section does not apply to a client in housing search or only on housing-related services, such as GOSH services, without also being stably housed. To verify the client’s housing was coordinated through ALTSA, submit an email to the [regional ALTSA Housing Specialist](chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https:/www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA-Housing-Regional-Map.pdf). Please see [Chapter 5a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.docx) for more information.

The following steps must be completed in addition to procedures found in Long Term Care Manual [Chapter 3: Assessment and Care Planning](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx). Please note that you may need to do an Interim Assessment to complete the following steps:

**1. For an individual who is housed through ALTSA and is eligible for LTSS services but who is currently choosing not to receive them:**

1. Enter the following treatments as a need: “Community Integration”; “Housing Subsidy (HCS/AAA)”; “Supportive Housing (HCS/AAA)”, as relevant, and “Other”. Move the assessment to *Current* and assign the appropriate RAC for the Program the individual is eligible for and assign the WA Roads RAC (3120).
   1. The case worker may need to select “*I have refused waiver services*” from the “Client is eligible for” drop down to move the assessment to current.
   2. Enter authorization(s) using appropriate WA Roads Service Code(s).
   3. For WA Roads services such as Community Choice Guide, choose “Community Integration” on the Treatments screen in CARE. Complete the Sustainability Goals in CARE and incorporate as part of the WA Roads service referral to the provider.
   4. For Washington Roads stabilization items or services, such as essential household goods or furnishings or pest eradication select “Other” in treatments and select the appropriate provider type and frequency from the Provider List. List the service type in the comments.
2. Document the client’s approval to reduce the number of hours indicated to 0. Note in the SER that the client is utilizing a housing voucher and is eligible for WA Roads services.
   1. For clients who request fewer hours than are indicated on the Care Plan screen, follow the instructions in the LTC Manual [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx) Assessment and Care Planning, under the “Getting approval on the Plan of Care” section.
3. As needed, transfer the case to the local Area Agency on Aging (AAA) office per transfer policy. Program RAC must be opened prior to transfer. Do not transfer a case with an Assessment moved to History to the AAA. Contacts must be documented in the SER.
   1. If client qualifies for the Wellness Education newsletter, you can authorize that service.
4. During the duration of the service period, should WA Roads services be needed, complete a SER outlining:
5. The service you are authorizing and/or the items you are purchasing and how they are necessary for the client’s service plan.
6. The Supervisor’s approval to authorize WA Roads services.
7. The goal of services authorized.
8. If there is an immediate service need to prevent the client from losing housing, the HCS/AAA staff assigned must respond to the need promptly.
   1. For example, if the client needs to utilize Emergency Rental Assistance (ERA), the HCS/AAA staff should submit and ERA form to the regional ALTSA Housing Specialist.
   2. Upon approval of ERA, the HCS/AAA staff should authorize a CCG to make the ERA payment.
9. The CM should follow all assessment timelines, including completing an annual assessment.
10. Enter authorization(s) using appropriate WA Roads Service Code(s).

**Note**: Assigned HCS Case Manager must open Program RAC prior to transfer to AAA. You can open a Program RAC without then authorizing a service through that RAC.

**2. For an individual who is found ineligible for LTSS services, but who is eligible for WA Roads because ALTSA coordinated their housing voucher/subsidy:**

1. Assign the WA Roads RAC (3120) and move the assessment to History, but do not inactivate the case; you will still be able to authorize WA Roads services should they be needed as long as the WA Roads RAC is assigned.
   1. Per LTC Manual Chapter 27: “When an Annual or Significant Change CARE assessment results in a decrease in residential rate, in-home units or other service, or a termination of a service, the department must provide clients at least 10-days’ notice prior to implementing the reduction or termination.”
      1. Per policy, the CM should send a termination PAN for LTSS per current protocols (being 10 days before the current plan period).
      2. Add the option of “Other” to the PAN (in CARE) and, dependent on circumstances, enter:
         1. If a GOSH client, on the LTSS termination PAN, include this language:
            1. “Supportive Housing services via GOSH will continue for 90 days. GOSH services will end (xx/xx/xxxx).”
            2. Please note, the GOSH Program Manager is the one to send the GOSH services termination PAN. The GOSH Program Manager will send this PAN after the 90-day period noted above.
            3. The GOSH Program Manager will extend RAC 3131 and the Supportive Housing authorization for the 90-day period.
            4. And the HCS/AAA CM will extend the WA Roads RAC.
         2. If the client is an ALTSA Subsidy holder, include this language:
            1. “While your Long-Term Services and Supports are being terminated, your housing subsidy/rent assistance is not being terminated. Your ALTSA Housing Program Manager will mail you a letter with more information about keeping your housing subsidy/rent assistance.”
   2. The HCS/AAA case manager should hold the case for 90 days.
   3. If there is a determination that the individual needs and wants LTSS within the 90-day period, the HCS/AAA case manager should contact the HCS office for an Initial/Reapply assessment. Once the Initial/Reapply assessment is complete, the case is transferred back to the AAA.
   4. If there is no determination that the individuals needs and wants LTSS within the 90-day period, after a care conference with the Housing Program Manager, the HCS/AAA case manager may inactivate the case.
      1. For GOSH clients, at this time, the GOSH Program Manager will end the GOSH authorization and end RAC 3131 - LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC.
      2. The GOSH Program Manager will send the GOSH services PAN.
2. If WA Roads services are authorized to provide intermittent stabilization, the case manager and supervisor must utilize these services in the most cost-effective way. If the need for stabilization services becomes ongoing, the CM and supervisor should staff the case with the Housing Specialist to see if other service options would best fit the individual’s needs.

**3. For individuals who are residing in subsidized housing that was coordinated through ALTSA, whether through the state-funded ALTSA Subsidy or a federal voucher through HUD (NED/MSV/RVP and 811 vouchers), and are inactive:**

No action is required of the HCS/AAA until individuals are identified. Individuals could be identified in a variety of ways:

1. The public housing authority/landlord could contact the ALTSA Housing Program Manager regarding an issue or crisis, at which point the ALTSA Housing Program Manager will make the referral to the local HCS office; or
2. The individual may contact an office (HCS or AAA) directly if services are being requested.
3. HCS/AAAs can contact the ALTSA Program Manager and request a list of individuals residing in their PSA who are utilizing a housing voucher.
4. Once the individual is identified as a person whose housing was coordinated through ALTSA and there is a need for Washington Roads services:
5. Activate the case in CARE.
6. WA Roads services can be authorized as soon as the case is activated in CARE.
7. If the AAA is the first point of contact and there is need for a new Assessment, per policy, the AAA should contact the HCS office if an Initial or Initial/Reapply assessment is required. Once the Initial or Initial/Reapply assessment is complete, the case is transferred back to the AAA.
8. Do not delay authorizing WA Roads services for an immediate need during completion of the assessment process. If the client does not want to proceed with an assessment, WA Roads services can still be authorized.

### **6.6** **Governor’s Opportunity for Supportive Housing (GOSH) Services**

Supportive Housing (SH) is a philosophy and a program that is rooted in the belief that no one should have to prove “housing readiness*”* to be housed. The service is an evidence-based practice with decades of research, as well as personal and professional stories, that highlight the success of community living paired with intensive, personalized supports. A person is supported in the process of securing community-based, affordable housing of their choice along with individualized support to assist the person with stabilization and self-identified goals. SH adheres to the principles of Housing First, Harm Reduction, Trauma Informed Care, Motivational Interviewing, Person Centered Planning, and Strengths-Based Approach. Program participation, medication adherence, and abstinence are not required to keep one’s housing.

SH services are available in two ways for ALTSA recipients:

* + Individuals who are currently residing in the community may be eligible for Supportive Housing services under [Healthier Washington Medicaid Transformation:](https://www.hca.wa.gov/about-hca/healthier-washington/initiative-3-supportive-housing-and-supported-employment)  Foundational Community Supports (FCS) - Supportive Housing services. For more information about FCS-SH services, see [Chapter 30d](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2030d.docx).
  + Individuals who are currently residing at Eastern or Western State Hospital or can be diverted from these institutions may access Supportive Housing Services through the [Governor’s Opportunity for Supportive Housing (GOSH](https://youtu.be/DTAvZlmM1pQ)).

For more information about how Supportive Housing services can complement other Long-Term Services and Supports or for information on working with Supportive Housing clients who are not currently receiving personal care services, please see [LTC Manual Chapter 30d: Foundational Community Supports: Supportive Housing](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2030d.docx), specifically the ***Supportive Housing and Case Coordination*** section. For more information or materials on ALTSA [Supportive Housing Services](https://www.dshs.wa.gov/altsa/stakeholders/supportive-housing-services), please see our website.

#### History

In 2016, as part of the Governor’s Behavioral Health Innovation Fund, created in [ESSB 6656](http://lawfilesext.leg.wa.gov/biennium/2015-16/Htm/Bill%20Reports/House/6656-S.E%20HBR%202ND%2016%20E1.htm), ALTSA was awarded a small amount of state funds to pursue Supportive Housing services for individuals eligible for discharge from Eastern or Western State Hospitals. The original budget allowed for approximately 15 individuals to transition out of the state hospitals with Supportive Housing services with the option of a state-funded housing subsidy. ALTSA began contracting directly with community Supportive Housing Providers and the Governor’s Opportunity for Supportive Housing (GOSH) was born.

In the 2017-2019 enacted budget, funding for GOSH was expanded and ALTSA was authorized to hire 3 FTEs dedicated to GOSH Program Management across the state. The ALTSA State Hospital Discharge and Diversion (SHDD) unit was also created. While GOSH pre-dates SHDD, it is one part of this larger initiative that has been approved by the state legislature under Mental Health Transformation.

**Note:** For more information on HCS assessment and transitions for those currently residing in the state psychiatric hospitals, please see [LTC Manual Chapter 9b: State Hospital Assessments](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209a.docx).

#### Eligibility

The GOSH service is available for individuals who are choosing In-Home setting and:

· are willing to work with a Supportive Housing Provider, and

· qualify for ALTSA services (financially & functionally eligible), and

· are discharging or being diverted from Eastern or Western State Hospitals,

· Diversion is defined as: An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90 or 180 day commitment order.

· If you have a diversion client that was discharge from the hospital immediately after an assessment was completed. If you still have contact with the client, a referral can be made 30 days post discharge.

**GOSH Eligibility Expansion**

To ensure ALTSA’s mission to transform livesby promoting choice, independence, and safety through innovative services, GOSH eligibility has been expanded to include:

* ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.

**Note:** An ALTSA client who is discharging or diverting from Eastern or Western State Hospital who already has an apartment or other independent housing in the community can still be referred to GOSH for transition support and intensive, ongoing tenancy support services to help maintain their housing.

**Presumptive Eligibility**

Through the Medicaid Transformation Project 2.0. Long-Term Services & Supports (LTSS) Presumptive Eligibility (PE) is an opportunity for individuals to quickly access an abbreviated benefit package of services while full functional and financial eligibility are being determined. One service included in the Presumptive Eligibility NFLOC package is Supportive Housing.

* Where does Presumptive Eligibility and GOSH Overlap?
* Phase 1 of Presumptive Eligibility is for ALTSA clients who are discharging or diverting from an acute care hospital and/or a psychiatric hospital, and have an ITA hold in this setting, are eligible for GOSH.

**“Is a person experiencing homelessness ineligible for Presumptive Eligibility?”**

GOSH clients are eligible to utilize the Motel for Interim Stay Transitions (MIST) program. MIST can be authorized for up to 6 months. If the ALTSA client qualifies for Presumptive Eligibility, desires GOSH, and has no safe place to stay or resources to pay for a place, the HCS/AAA case manager can utilize MIST. When a GOSH recipients are paired with MIST, they are not considered homeless and can then access the PE benefits.

***Please note, acceptance into the GOSH program is contingent on provider capacity and discretion.***

#### 

#### GOSH Referral Process

1. Obtain confirmation that the client would like to be referred for Supportive Housing (SH) services and additional information needed for GOSH Referral Form. Please note, there is no participation for Supportive Housing.
2. Completely fill out [DSHS Form 11-153](http://forms.dshs.wa.lcl/formDetails.aspx?ID=74562), “Governor’s Opportunity for Supportive Housing (GOSH) Referral” and email to your Regional GOSH Referral inbox:

DSHS Region 1: [R1GOSHReferral@dshs.wa.gov](mailto:R1GOSHReferral@dshs.wa.gov)

DSHS Region 2: [R2GOSHReferral@dshs.wa.gov](mailto:R2GOSHReferral@dshs.wa.gov)

DSHS Region 3: [R3GOSHReferral@dshs.wa.gov](mailto:R3GOSHReferral@dshs.wa.gov)

The email must include all additional required documents as attachments, as outlined on the GOSH Referral. Please note:

* 1. For referrals meeting diversion criteria to be verified, CMs must include a copy of the court commitment paperwork, signed by a judge or commissioner, which documents that:
     1. the client is on a 90- or 180-day commitment order for further involuntary treatment, or
     2. the client is on a civil commitment detainment under the Involuntary Treatment Act (this includes 120-hour, 14-day, 90-day or Revoked 90/180 LRA orders).
  2. Commitment orders must be verified and uploaded to DMS by Primary CM. State Hospital screen needs to be updated.

If a client meets diversion criteria and is being case managed by an Area Agency on Aging (AAA), the AAA CM may refer the client for GOSH.

1. As of the March 31, 2023 CARE Release, GOSH is on the State Hospital/Hospital/E&T screen in CARE. When you are entering a client’s most recent psychiatric hospital stay, you now will be prompted to enter if a GOSH referral was made, the referral date and whether they were approved for GOSH. If you select “no” for “Was GOSH referral made?” there will be no further questions.
2. If a client is eligible for GOSH, the SHPM will make a direct referral to the ALTSA contracted Supportive Housing Provider (SHP) and complete a Service Episode Record (SER) with their actions. The SHP has two business days to respond to the SHPM.
3. If a client is not eligible for GOSH, the SHPM will inform the referring CM by email and enter a SER with this information.

#### [GOSH Client Accepted](https://youtu.be/DyCerTNs2ZU)

1. Once the referral has been accepted by the SHP:
   1. The SHPM will communicate this through a secure email to CM, additional care team (discharge social worker, MCO liaison, Peer Bridger, Outpatient Behavioral Health Provider, etc.) and the SHP. The SHPM will update their section of [DSHS Form 11-153](http://forms.dshs.wa.lcl/formDetails.aspx?ID=74562) and include the complete referral form as an attachment in their email.
   2. The referring CM will submit the GOSH Referral to DMS.
   3. The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. The SHPM will document these actions in a SER.
      1. RAC 3131 is the RAC the SH service code is tied to.
      2. It is the SHPM’s responsibility to open, extend and close authorizations for service code SA299, U1.
      3. It is the CM’s responsibility to complete the remaining steps for authorization of services, as outlined in [LTC Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx), including complete electronic form [DSHS 14-443](http://forms.dshs.wa.lcl/formDetails.aspx?ID=4997) in Barcode.
   4. The SHPM will create and send the client a Planned Action Notice (PAN) informing them that SH services are approved.
2. Once client is authorized for Supportive Housing, the CM must:
   1. Add Supportive Housing Provider to Collateral Contacts screen
   2. Add “Supportive Housing” as a Treatment
      1. On the Medical Screen in CARE, choose the Program “Supportive Housing (HCS/AAA)”
      2. Check “No” for Received in the Last 14 days?
      3. Check “Yes” for Need
      4. Choose “Agency” for the Provider
      5. Choose “PRN” for Frequency
      6. For Comments, type: “*Client has been referred to the Governor’s Opportunity for Supportive Housing (GOSH) service. [Enter name of Supportive Housing Provider] to assist with pre-tenancy search for affordable housing or transition back to their apartment, assist with community integration, and to provide ongoing intensive tenancy support services.”*
      7. The Supportive Housing treatment identifies a client who is receiving Supportive Housing services through the Governor’s Opportunity for Supportive Housing (GOSH) or Foundational Community Supports - Supportive Housing. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.
      8. When “Supportive Housing (HCS/AAA)” is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:

Graphical user interface, text, application

Description automatically generated

This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.

* 1. If client is receiving the GOSH Subsidy, add “Housing Subsidy (HCS/AAA)” as a Treatment
     1. On the Medical Screen in CARE, choose the Program “Housing Subsidy (HCS/AAA)”
     2. Check “No” for Received in the Last 14 days?
     3. Check “Yes” for Need
     4. Choose “Agency” for the Provider
     5. Choose “PRN” for Frequency
     6. For Comments, type: “*Client will be receiving the ALTSA Housing Subsidy administered by Spokane Housing Authority.”* The Housing Subsidy treatment identifies a client who is receiving the ALTSA rental subsidy. This subsidy is paid for and managed by ALTSA and should be added when an individual receives the subsidy. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.
     7. When "Housing Subsidy (HCS/AAA)" is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:

Graphical user interface, text, application

Description automatically generated

* + 1. This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.
  1. Add “Other” for Community Supports under Treatments
     1. On the Medical Screen in CARE, choose the Program “Other”
     2. Check “No” for Received in Last 14 days?
     3. Check “Yes” for Need
     4. Choose “Agency” for Provider
     5. Choose “PRN” for Frequency
     6. For Comments, type: *“Community transition items and services as identified to assist with the client’s return to independent living.”*
  2. Add the Supportive Housing Provider as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of “Supportive Housing (HCS/AAA)” and “Other” (for Community Transition Services)
  3. If the client is receiving the GOSH Subsidy, add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the task of “Housing Subsidy (HCS/AAA)”
  4. Please note, per Case Management policy, a task must be assigned to a Paid Provider to move an assessment to Current. You do not need to assign all paid tasks specifically to a paid care provider in order to move an assessment to Current. For GOSH clients who only have Supportive Housing services at the time of the assessment, adding the Supportive Housing Provider as a Paid Provider and assigning the provider the paid task of “Supportive Housing (HCS/AAA)” will suffice to move the assessment to Current. Do not assign the Supportive Housing Provider caregiving tasks.
  5. Use the Purpose Code “Housing” for any SERs related to GOSH services or subsidy.
  6. If there are any issues or concerns regarding a GOSH client, including eligibility concerns, protocol is for the case manager to staff with SHPM. Do not close a GOSH client prior to staffing with a SHPM.

**Note:** DSHS contracts directly with GOSH SHPs and the scope of work is spelled out in the contract. Therefore, SHPMs and CMs do not fill out the Sustainability Goals screen in CARE for SHPs.

#### [GOSH Discharge Planning](https://youtu.be/z5BKwZY7F1U)

1. Once Supportive Housing Provider (SHP) accepts the client, they start working with the client on:
   1. Paperwork – running a background check, Housing Assessment form, GOSH subsidy, rental applications, etc.
   2. Documentation – in partnership with the discharge workers, ensuring the client has a current ID or someone is working with the client on obtaining a current ID, Social Security card, income verification letters, etc.
   3. Independent housing search – the SHP does not conduct residential searches.
   4. Determining what items the client has or can access through community resources and items the SHP might request CM to authorize through the appropriate Community Transition services (e.g., furniture, household items, phone).
   5. Discussion around all services the client needs in the community – these conversations should be ongoing with the client and the care team.
2. Best practice is for the SHP to provide weekly email updates to the care team (CM, SHPM, discharge social worker, MCO liaison, Peer Bridger, Outpatient Behavioral Health Provider, AAA as applicable, etc.).
   1. If you are not hearing from the SHP, reach out to the provider directly to request client updates.
   2. If you have ongoing communication challenges with the SHP that you are not able to work out directly, elevate to the SHPM for support.
3. Multidisciplinary meetings will determine which agency/provider will address service referrals pending community transition.

If need for additional staffing or more support needed from multidisciplinary team, CM can consider reaching out to Regional Transition Coordinator to add client to the appropriate Cross Systems committee staffing.

1. SHPM available for any support needs. If there are issues or concerns regarding a GOSH client, including eligibility concerns, protocol is for the case manager to staff with SHPM. Do not close a GOSH client without staffing with SHPM.

**Note:** When an ALTSA client is already enrolled in a housing service (GOSH, MIST, housing voucher) and any type of assessment (Initial, Annual, Interim, or Significant Change) is conducted with the client, and there is a possibility client is no longer functionally eligible for LTC services, HCS/AAA CM will review the assessment with the client prior to scheduling a staffing with SHPM, and before moving the assessment to current/history. A SER note is required for the assessment review with the client.

**Once discharge date has been set:**

Best practice for is the CM or SHP schedule a discharge planning conference meeting approximately 7-10 days in advance of a discharge. The timeline might be shorter for clients discharging from an Evaluation and Treatment Facility or inpatient from an acute care hospital.

1. Meeting should include:
   1. HCS CM, Public Benefits Specialist, Discharge SW, SHP, receiving AAA or HCS CM (if transitioning to Interim Setting), MCO Liaison, Outpatient Behavioral Health Team, Peer Bridger, Caregiving Agency supervisor (if known), client and any support individuals.
2. Discharge Planning Call should cover:
   1. Discharge logistics (e.g., transportation, personal items of client, medications – how much will they discharge with, what prescriptions, etc., what pharmacy, any cash that client received while working or “gate” money, confirmation they have a copy of their ID and Social Security card, etc.).
   2. Overview of the state of the apartment (furniture, food, household items, etc.).
   3. Overview of appointments for the first week and discussion on who will be assisting in transportation.
   4. Discussion on what “after care” services the client will have once discharged and what additional supports or services need to be authorized and by whom.
   5. Financial logistics (will food stamps be turned on, what cash benefits will client receive, who will coordinate taking client to DSHS or Social Security Administration office, etc.).

An Interim Housing Option is considered anything outside of a client’s own apartment/house. Examples include: HCS residential setting, Adult Residential Treatment Facility, Transitional Housing, motels, family/friends, etc.

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#### GOSH Interim Setting Process

ALTSA’S GOSH program supports in-home transitions for those discharging/diverting from Eastern or Western State Hospital by connecting them with a Supportive Housing Provider (SHP). The SHP works to transition clients to an independent apartment in the client’s community of choice with supports. Apartments are not always secured before discharge occurs. Rather than delaying discharge, and when a client is in agreement, an interim setting may be sought while a client is waiting for housing to be secured.

To ensure there are no interruptions to Supportive Housing services or the independent housing search, any transitions in case management or the service team should include the ALTSA Supportive Housing Program Manager (SHPM) and Supportive Housing Provider (SHP) in communication and coordination. The Housing Team encourages discharge planning calls in advance of any transitions to an interim setting.

Please note: the role of the SHP is to search for independent housing. If a residential setting is being pursued as an interim setting and the CM is unable to conduct this search directly, they can look into the authorization of a Community Choice Guide (CCG) to search for and secure a residential setting for the client. The CCG should not also conduct a search for independent housing, as this would be a duplication of services with the SHP. The SHP’s independent housing search does not cease during this period unless the participant no longer wishes to live independently or participate in GOSH.

**“Does GOSH services end if client cannot return to their previous residential setting & is admitted to the hospital?”** No, if the GOSH client cannot return to their previous residential setting, the residential case manager will transfer the case immediately to an HCS hospital case manager. See Chapter 9 for additional information.

**When to use the Interim Setting process**

1. An individual has been deemed ready to discharge prior to independent housing being secured and all parties agree that a continued stay is not in the individual’s best interest.
2. The individual requests an interim setting and all parties agree it is a safe, viable discharge plan while waiting for independent housing.
3. An individual is diversion eligible and ready for/must discharge from their current setting.

**When not to use the Interim Setting process**

1. To explore a participant’s “housing readiness.”
2. An individual has been approved for independent housing, but the move-in date has delayed discharge. For example, repairs need to be made on the unit, so the move-in date is four weeks out. In this instance, every effort should be made to have the person wait in the State Hospital or diversion facility to avoid the extra move.

**Procedures**

1. HCS Case Managers search for interim housing options that are willing to accept clients in an interim status as they wait for independent housing through GOSH. It is important to locate an interim housing option in the county where the participant intends to reside permanently as this will aid the housing process. If an interim housing option is not available in the county the participant intends to reside in permanently, speak with your SHPM.
2. Once an interim housing option has been identified, the HCS/AAA Case Manager will speak with the client and/or their authorized representative and explain the temporary nature of the interim housing option while the client is still working with their SHP on securing independent housing. The HCS/AAA Case Manager will get verbal confirmation from the client that they understand and agree with this plan.
3. If an HCS residential setting is being utilized as an interim housing option, the HCS/AAA Case Manager will speak with the owner/operator/manager of the residential setting and explain that the client will reside there while they pursue independent housing. The HCS/AAA Case Manager will get verbal confirmation from the owner/operator/manager that they understand the client will be working with their SHP to find independent housing and that once independent housing is found, the client will be moving out of this setting.
4. For interim housing options that are not HCS residential settings, prior to transition, the HCS/AAA Case Manager will speak with the appropriate representative to inform them that the client is working with a SHP on securing independent housing.
5. Regardless of interim housing option, prior to transition, the HCS/AAA Case Manager will notify the SHP of the contact information for the appropriate representative of the interim housing.
6. After completing items 1-5, HCS/AAA Case Manager must enter the following SER:

“The writer has spoken with this client and/or their authorized representative and explained the temporary nature of the interim option and they understand and agree with this plan.

The writer has spoken with the owner/operator/manager of [*enter facility name*] and explained that the client will reside at this facility as an interim setting as they pursue independent housing and understand that this is temporary.

Appropriate representative of the interim housing understands client will be working with Supportive Housing team to find independent housing. Provider also understands that once independent housing is found, client will be moving out of this setting.

I have notified the SHP the contact information for the appropriate representative of the interim housing.”

1. Depending on the type of facility selected as the interim setting, the following will take place:

1. **Adult Family Home (AFH):** If both client and home approve of the placement, HCS Case Manager will transfer the case to the local HCS office and communicate that the client is on GOSH and working with a SHP.
2. **Adult Residential Treatment Facility (ARTF):** HCS Case Manager should approach the local AAA Office to determine if they are willing to accept the case while the client is at an ARTF. If the AAA office declines, the case will be kept open and transferred to the local HCS office. Transferring HCS Case Manager should communicate that the client is on GOSH and working with a SHP.
3. **All Interim Settings that are not licensed should be considered “In-Home”:** HCS Case Manager should authorize needed Long-Term Services and Supports while the client is staying in the interim setting. HCS Case Manager should approach the local AAA office to determine if they are willing to accept the case. If AAA office declines, the local HCS office should hold the case. Transferring HCS Case Manager should communicate that the client is on GOSH and working with a SHP.
4. **Regardless of Interim Setting:**

* HCS or AAA CM keeps the case open. SHP will work with HCS/AAA Case Manager for authorization around Community Transition and Sustainability Services.
* SHP should schedule time with interim setting staff working with the client (if applicable) and new HCS/AAA Case Manager to clarify roles and responsibilities and provide housing search updates.
* SHP should include new HCS/AAA Case Manager in regular updates regarding housing search. Interim setting staff should be included as appropriate (if applicable).
  + If a client is re-hospitalized or jailed, they are not automatically exited from their GOSH services or subsidy. GOSH is a state-funded service and, as noted in Chapter 3, page 3.26, state-only exceptions exist for paying for services when a client is institutionalized. Supportive Housing Providers continue to provide support services to clients through short-term hospitalizations or jail stays. Service authorizations are to remain open and clients active, as Supportive Housing Providers continue to work with the clients and the GOSH subsidy continues to be provided.
    - If you are made aware that a participant is in jail – staff case with the GOSH Program Manager. If a participant faces multiple court hearings, hold the case until final decision of the court is carried out. During this time, HCS/AAA CM, GOSH Provider and GOSH PM will have regular staffing meetings. GOSH program and HCS/AAA will still hold case on their case load. GOSH authorization remains active and the GOSH Provider is billing during this time.
    - If you are made aware that a participant is institutionalized – keep case open, regular staffing will occur between HCS/AAA CM and GOSH Provider. GOSH Provider will follow up with hospital/institution regarding the status of the client and provide updates to HCS/AAA CM. GOSH authorization remains active and the GOSH Provider is billing during this time.
    - If you have any questions or concerns, reach out to your Regional SHPM. Do not close a GOSH client prior to staffing with a SHPM.

**Transition to Independent Living**

Can a SHP conduct the search for interim housing?

* Yes. Priority should be spent pursuing independent housing options, but the SHP could use community relationships and knowledge to secure interim housing if that is the goal of the participant. Independent housing search should not cease during this period unless the participant no longer wishes to live independently or participate in GOSH.

Can a HCS CM authorize a Community Choice Guide (CCG) to conduct the search for interim residential housing if participant is working with a SHP?

* Yes. The SHP may not be familiar with specific LTSS residential settings in the community. If the HCS CM is unable to conduct the search for an interim residential setting, the CM can authorize a CCG to search for and secure a residential setting for the client. Please note, the CCG should not also conduct a search for independent housing, as this would be a duplication of service with the SHP. The HCS CM should review with GOSH PM to determine most efficient course of action.

Once the client has moved into their own apartment:

* 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization’s end date matches the CARE Plan end date.
  2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044.
     1. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP’s contract:
        1. The tenancy service code may start the first full day in independent housing, OR
        2. The tenancy service code may start after a 90-day transition period in independent housing.
     2. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044.
  3. The SHPM will document these actions in a SER.
  4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
  5. If the case has not yet been transferred to the local Area Agency on Aging (AAA), it is best practice to have a meeting between the HCS CM, assigned AAA CM and GOSH Provider. If it is not feasible to have this meeting, the HCS CM should let the GOSH Provider know they are transferring the case and the assigned AAA CM should reach out to the GOSH Provider to let them know they are now case managing the case.
  6. The SHP continues to provide intensive tenancy support services and work with the care team for cross-system collaboration.
  7. At the time of Annual Assessment, the assigned HCS/AAA CM should reach out to the GOSH Provider as a collateral contact. The GOSH Provider provides an array of support to a client and the CM should speak with them about the services they are providing the client as part of the assessment process.
  8. SHPM remains available for any support needs.
  9. If a client is re-hospitalized or jailed, they are not automatically exited from their GOSH services or subsidy. GOSH is a state-funded service and, as noted in Chapter 3, page 3.26, state-only exceptions exist for paying for services when a client is institutionalized. Supportive Housing Providers continue to provide support services to clients through short-term hospitalizations or jail stays. Service authorizations are to remain open and clients active, as Supportive Housing Providers continue to work with the clients and the GOSH subsidy continues to be provided.
     1. If you are made aware that a participant is in jail, staff case with the GOSH Program Manager. If a participant faces multiple court hearings, hold the case until final decision of the court is carried out. During this time HCS/AAA CM, GOSH Provider and GOSH PM will have regular staffing meetings. GOSH program and HCS/AAA will still hold case on their case load. GOSH authorization remains active and the GOSH Provider is billing during this time.
     2. If you are made aware that a participant is institutionalized, keep case open, regular staffing will occur between HCS/AAA CM and GOSH Provider. GOSH Provider will follow up with hospital/institution regarding the status of the client and provide updates to HCS/AAA CM. GOSH authorization remains active and the GOSH Provider is billing during this time.
     3. If you have any questions or concerns, reach out to your Regional SHPM. Do not close a GOSH client prior to staffing with a SHPM.

**Note:** The SHPMs are responsible for opening, modifying and closing Supportive Housing service codes (SA299, U1 for pre-tenancy and H0044 for tenancy). Authorization of these service codes cannot be made by case managers as they need HQ approval. If a case manager attempts to open, modify, or close these service codes, the authorization will go into error.

#### When performing a CARE assessment for a GOSH client, consider the following:

1. Ask the client who they would like to attend the assessment appointment with them. Offer suggestions for who may be helpful in providing useful information (family, friends, Supportive Housing Provider, etc.).
2. Gather information from the client’s legal representative or substitute decision-maker, as appropriate.
3. Gather other information from collateral contacts if it is needed to complete the client’s assessment.

See [Chapter 3.docx (live.com)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25203.docx&wdOrigin=BROWSELINK)

#### GOSH State Subsidy

The ALTSA GOSH Subsidy is a state funded housing subsidy that is available for individuals discharging or diverting from Western State Hospital or Eastern State Hospital. The subsidy is paired with Supportive Housing services that assist with transition and follow the person in the community to support housing stabilization over the long term. For more information on the ALTSA GOSH Subsidy, please see [6.4](#_The_ALTSA_GOSH)

#### Reimbursements

DSHS contracts directly with GOSH SHPs. While GOSH SHPs are reimbursed for Supportive Housing services, there are no set aside monies tied to GOSH for goods. GOSH is a Long-Term Service and Support that funds Supportive Housing services and a housing subsidy. In order to support the GOSH participant’s transition and sustainability in independent housing, CMs should utilize [Community Transition Services](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209b.docx), [Community Transition and Sustainability Services](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209b.docx) or [Washington Roads](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.doc), dependent upon participant eligibility. With prior approval from the AAA/HCS CM or SHPM, the SHP is reimbursed by the CM for the authorized purchases after it is verified that the individual received the goods. If a CM has questions or concerns about a SHP’s invoice, the CM should communicate these concerns directly with the SHP. If there are repeated concerns, after attempts have been made by the CM to clarify, reach out to your Regional SHPM.

Based on an individual’s eligibility, the following services could be reimbursed to the SHP: tenant background screening to aid housing search, paying for rental deposit and first month’s rent, utility hookup fees, purchase of furniture, purchase of essential items including needed clothing, assistive technology through Washington Roads, and/or emergency rental assistance, etc.

For more information regarding Community Transition Services and Community Transition and Sustainability Services, including eligible goods/services, appropriate RACs and service codes to reimburse purchases, please review the CTS and CTSS sections in the LTC Manual [Chapter 9b: State Hospital Assessments](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%209b.docx). For more information regarding Washington Roads, including eligible goods/services, appropriate RACs and service codes to reimburse purchases, please review LTC Manual [Chapter 5a: Washington Roads.](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.doc)

#### How is this funded?

Governor’s Opportunity for Supportive Housing is one part in the larger State Hospital Discharge and Diversion (SHDD) initiative that has been approved by the state legislature under Behavioral Health Transformation. These services and subsidies are funded 100% through state dollars. Utilizing state dollars only allows for greater flexibility than programs also receiving federal funding. If you have policy questions on working with GOSH participants, please contact your GOSH Program Manager.

**Note:** There is no participation required for GOSH services.

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#### Can a DDA services recipient receive GOSH services?

An individual receiving DDA services who is transitioning out of or diverting from Eastern or Western State Hospital, meets all other eligibility criteria, and can exit the hospital on an ALTSA program is eligible for GOSH. An individual receiving DDA services who is already residing in the community is not eligible for GOSH Supportive Housing.

#### What about contracting?

Governor’s Opportunity for Supportive Housing contracts are executed and held at ALTSA headquarters. All contractors providing Governor’s Opportunity for Supportive Housing services must have a current contract for waiver or RCL/WA Roads individual services before providing services.

Services are performed within the scope of practice of the contractor’s license and in compliance with professional rules, as defined by law or regulation, and are provided in a manner consistent with protecting and promoting the individual’s health and welfare, and appropriate to the individual’s physical and psychological needs.

If you know of an agency that is interested in contracting for GOSH, please refer them to [Becoming a GOSH Provider](https://www.dshs.wa.gov/altsa/stakeholders/becoming-gosh-contracted-provider) for more information.

**Note:** In addition to specific contracted duties, each provider is responsible for reporting any instances of abuse, neglect, or exploitation of a vulnerable adult or child.

## 6.7 Emergency rental assistance (ERA) SA298

ERA can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.

ERA does not include pre-tenancy deposits or move-in costs, including first month’s rent, required at move in. There are other resources that may cover these one-time expenses; please see service codes [SA297](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA297_Community_Transition_or_Sustainability__Services_Federal_Match.docx) or [SA291](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA291_Community_Transition_or_Sustainability__services.docx).

**How to submit an ERA request?**

Completely fill out the [ERA referral form](#ERA), and email it to [emergencyrentalassistance@dshs.wa.gov](mailto:emergencyrentalassistance@dshs.wa.gov). In the email subject line put the region where client is residing. Local supervisor approval for the request is required prior to submission to the ALTSA Housing Team for review. The client’s plan to pay ongoing rent, should be specified in detail in the space provided on the form.

**How is payment made to the landlord?**

A Contracted Provider is authorized by the case manager to make the ERA payment directly to the landlord and receive reimbursement using ERA service code [SA298](http://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA298_Emergency_rental_assistance.docx). The CM will receive an approval email from the Regional Housing Program Manager.

To issue payment:

1. Authorize a contracted provider (Community Choice Guide or GOSH Supportive Housing Provider) with the capability to make payments on client’s behalf.
2. **When you have the invoice**, including receipt:
3. Use **RAC 3131.**
4. Use Service Code **SA298** to reimburse the provider for the expense.
5. You also may authorize up to 4 units for making the payment to the landlord/property manager. Use code **SA266**. Please note these additional units are to be authorized for CCGs only. A GOSH Supportive Housing provider will not need to be reimbursed additional units to make the payment.
6. The codes can be opened and closed the same day.
7. If utilizing a CCG, make a note in the sustainability goal section of CARE that the person has been approved for Emergency Rental Assistance. If utilizing a GOSH Supportive Housing Provider, note the use of the assistance in a SER.

**What is the required documentation for my client to apply?**

The only required documentation is the complete ERA form (link above or at the bottom of this document). HPMs will review your client’s request and respond with an approval or denial email. HPMs try to respond to ERA requests within 24 hours.

## 6.8 Motel Interim Stay for Transitions (MIST)

The Motel Interim Stay for Transitions (MIST) is a service to pay for a short-term motel/hotel stay offered to minimize the number of voucher/subsidy holding clients who discharge to and/or experience episodes of homelessness while in housing search. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client’s chances of ending up on services in their own home. The service is authorized for a 6-month period at a time. MIST currently cannot be offered to clients who do not have a housing subsidy/voucher in hand to utilize.

**Eligibility Criteria: Client must meet one of the following criteria:**

1. **Bridge Subsidy:** ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search.
   * MIST should not be used to transition a client out of the SNF unless they cannot stay (ex: insurance stops paying, behaviors, etc.).
2. **GOSH Program:** ALTSA clients who are enrolled in the Governor’s Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness.
3. **Civil Transitions Program:** Individuals who are referred through the Civil Transitions Program.
4. **Other Housing Resource:** 
   * ALTSA clients who will be living independently and currently have a resource from a housing agency or program.
   * Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HOPWA, VA, etc.
   * ALTSA clients who have been approved for a project-based resource and move-in-date.
   * Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency.

***\*Clients on a voucher or subsidy wait list do not qualify for MIST.***

1. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate.

* Ex: Pest control or eradication, fire, or flooding.
* ***Approval is at program discretion.***

1. **Limited Residential:** ALTSA clients who are homeless with nowhere to stay, including an emergency shelter, and have a verifiable move-in-date within 30 days to a residential setting, such as an Assisting Living Facility or Adult Family Home.

* Authorization is for 1 month only.

**MIST Referral Process**

1. Once referral has been accepted by the Housing Program Manager (HPM):
   * 1. The HPM will communicate this through an email to referring CM and will SER note the following “*The request for the Motel Interim Stay for Transitions (MIST) for [client name] is approved. The approval period is for six months, [start date, end date], but the authorizations must be made in two-week increments.”*
     2. HPM will provide the HCS/AAA case manager with the Participant Agreement form. HCS/AAA CM or Contracted Provider will verbally review this form with the client. Individual who reviews the Participation Agreement form will need to complete the form and email it back to the HPM.
     3. HCS/AAA CM will need to enter a SER note stating that the client has been approved for Motel Interim Stay for Transitions funds.
     4. HCS/AAA CM will coordinate with Contracted Provider and notify them that client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. HCS/AAA CM will inform Contracted Provider that HCS/AAA CM, upon receive of invoice, will be reimbursing Contracted Provider on a two-week timeline for a period of up to six months. HCS/AAA CM will let contracted provider know that if there are any changes, the provider must notify HCS/AAA CM.
     5. If Contracted Provider notifies HCS/AAA CM of the following changes (client has not secured independent housing in the six-month approval period and the authorization is ending, or client is no longer requiring MIST, or client has left the hotel and has not returned), the HCS/AAA CM should notify the SHPM immediately.

Note: provide service end date and outcome if client is no longer needing MIST.

* + 1. If there are any issues or concerns regarding a MIST client, including eligibility concerns, protocol is for the case manager to staff with SHPM. Do not close a MIST client prior to staffing with a SHPM.

**How is payment made for MIST?**

1. Contracted Provider will submit to HCS/AAA case manager an invoice and receipt for the motel/hotel cost.
2. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt and invoice have been received.**
3. Use RAC (to be provided by HPM).
4. Use Service Code (to be provided by HPM) to reimburse the contracted provider for the expenses incurred.
5. HCS/AAA CM will place authorization in “Reviewing” status until an invoice and receipt is received by the HCS/AAA CM.
6. Once HCS/AAA CM receives invoice and receipt, HCS/AAA CM will verify the amount on the receipt matches the “Reviewing” status authorization. If the amount on receipt doesn’t match what is in “Reviewing” status, CM will update the amount.
7. HCS/AAA CM will update the authorization start and end date to match the receipt’s dates of service.
8. HCS/AAA CM will move the authorization from “Reviewing” status to Approved.

## 6.9 Guidance on Working with clients who are homeless

The following information will assist case management staff in determining options for working with clients who are eligible for Long Term Services and Supports (LTSS) and are currently homeless or facing housing instability.

**May a client receive personal care or other LTSS in a shelter, RV or other location that is outside the typical in-home setting?**

Yes, *in-home* refers to settings other than institutional or licensed residential and does not require that a person reside in a house or apartment. LTSS may be provided in an alternative setting when there is a provider available to meet the client’s request. If you have questions, please consult with your HPM.

[WAC 388-106-0270](https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-0270): What services are available under community first choice (CFC)?

[WAC 388-106-0030](https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-0030): Where can I receive services?

**The** [**Challenging Cases Protocol**](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205.docx) **can also be used, and is often necessary, when working with clients who are experiencing homelessness.**

**What can I do when I have assessed a client who is homeless and there are no possible in-home locations to provide personal care?**

* Look into eligibility for [Foundational Community Supports (FCS) - Supportive Housing (SH) or GOSH](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2030d.docx)
* Consider eligibility for [FCS-Supported Employment](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2030c.docx)
* If the client has access to any housing opportunities and is not FCS-SH eligible, consider referring the client to [Community Supports Transition Services](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207b.doc), [COPES](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207d.docx) or [WA Roads](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.doc) to work with a Community Choice Guide to find housing
* If the client has behavioral challenges that are affecting the establishment of LTSS, consider making a [Behavioral Supports H2019](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.doc) (Chapter 5a) referral
* If a client is initially declining personal care services, it is allowable to use the COPES [Wellness Newsletter](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207d.docx) to keep a client open while working on a different Care Plan
* Before closing a case for a client who is homeless but open to accepting services, consult the [Challenging Cases Protocol](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205.docx) and consider contacting your regional HPM to see if they are aware of any resources that may be available
* Also see section 5.B9 for [Community Resources for Housing](#_5B.8_Community_resources)

**How do I document working with a client who is experiencing homelessness and declines all services?**

Some clients experiencing homelessness go through the ALTSA assessment process multiple times as referrals for an intake are made by community providers (hospitals, shelters, etc.). It is important to document through a SER the reason the client is declining services, and the strategies used to engage the client in accepting services or locating a reasonable setting for the client to receive those services. It is also important to list any information given by collateral contacts so that the information can be referred to in future contacts with the client.

## 6.10 Documenting altsa housing resources in care

**What** **are the changes or additions I need to make in CARE when I refer a client to an ALTSA housing resource?**

It is important to document that your client will be receiving an ALTSA housing resource so that if/when the case transitions, the information can be communicated to the new case manager. When a client has been offered an ALTSA housing resource, the following additions can be made in CARE:

All SERs regarding housing should be entered using the ***Housing* purpose code**.

**For clients utilizing the ALTSA Subsidy**, the HCS CM must enter the following into the CARE assessment:

* + Add “Housing subsidy (HCS/AAA)” as a Treatment for ALTSA Bridge and ALTSA GOSH subsidy recipients
    - On the Medical Screen in CARE, choose the Program “Housing Subsidy (HCS/AAA)”
    - Check “No” for Received in the Last 14 days?
    - Check “Yes” for Need
    - Choose “Agency” for the Provider
    - Choose “PRN” for Frequency
    - For Comments, type: “*Client will be receiving the ALTSA Housing Subsidy administered by Spokane Housing Authority.”*
  + Add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of “Housing subsidy (HCS/AAA)”

For clients utilizing a **NED voucher or 811 unit**, the CM must:

* Adding or updating the Housing Program Manager in the collateral contact screen.

For clients utilizing **Foundational Community Supports or GOSH Supportive Housing**, the CM must:

* Add Supportive Housing (HCS/AAA) as a Treatment in the Medical Screen and in the Care Planning section, and under supports assign the authorized Supportive Housing Provider the task of Supportive Housing (HCS/AAA) and Other (for Community Transition Services).

## 6.11 Pairing services with Housing resources

Whether a client is using an ALTSA Housing Resource or a community housing resource, they may need Community Transition and/or Stabilization supports and/or services to be able to access or maintain housing. When a client has an opportunity to utilize a subsidy, or move into other affordable housing, these services and supports can be utilized. The following resources may be used to facilitate the moving process with the client. These resources can also be used to stabilize and sustain housing for a client to prevent a loss of affordable housing.

**How can I use Supportive Housing services to assist my client with a housing resource?**

Supportive Housing services are available in two ways for ALTSA recipients:

* + Individuals who are currently residing in the community may be eligible for Supportive Housing services under “[Healthier Washington Medicaid Transformation:](https://www.hca.wa.gov/about-hca/healthier-washington/initiative-3-supportive-housing-and-supported-employment) Foundational Community Supports (FCS): Supportive Housing services.”
  + Individuals with challenging or complex needs who are currently residing at Eastern or Western State Hospital or can be diverted from these institutions may access Supportive Housing Services through the Governor’s Opportunity for Supportive Housing (GOSH). For more information on GOSH, please see [Section 6.6.](#_5B.6_Governor’s_Opportunity)

Supportive Housing is a housing support service that can serve a client in assisting with pre-and-post tenancy tasks. The service is intended to support a client for as long as they need and want the service.

Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated, focused support services. ALTSA seeks to provide person-centered, responsive, low-barrier services for these individuals.

To learn more about the full spectrum of services that FCS Supportive Housing can provide, and the eligibility criteria and referral process for these services, please see [Chapter 30d](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2030d.docx).

**How do I use Community Transition Services (CTS)/Community Transition and Sustainability Services (CTSS)/WA Roads services to assist my client with a housing resource?**

Clients may access ALTSA CTS and CTSS, depending on their eligibility criteria. To determine which services to use, please see the corresponding LTC Manual Chapters:

* Community Transition Services (CTS) through Community First Choice, see [Chapter 7b](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207b.doc).
* Community Transition Services (CTS) through COPES, see [Chapter 7d](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207d.docx).
* Community Transition and Sustainability Services (CTSS) through WA Roads, see [Chapter 5a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.doc).
* To find out more about working with Community Choice Guides or Supportive Housing Providers to provide Community Transition or Sustainability Services for clients, please see the Community Choice Guides and FCS-SH Providers section of [LTC Manual Chapter 30d: Foundational Community Supports – Supportive Housing Services](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2030d.docx).

**Please note that individuals who are receiving an ALTSA Housing Resource are immediately eligible for WA Roads and the goods and services it provides (**[**Chapter 5a**](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205a.doc)**, p.3).**

All clients receiving an ALTSA Housing Resource (NED, 811, ALTSA Subsidy) have access to transition/stabilization services through the duration of their subsidy. Clients can access CTS/CTSS repeatedly for housing transition or stabilization needs. Regardless of the program through which your client can receive the transition/stabilization services, the goal of supporting clients in accessing and maintaining housing is the same. Pairing services and supports with a housing resource can provide the client a highly successful community transition and contribute to the person’s housing stabilization.

\***Please note**: Community First Choice and COPES services are always the priority programs for transition services. WA Roads services, in contrast, need supervisor approval because the services are paid for using state-only funding and may only be used when a waiver/state plan service does not address the client’s need. The links above to Chapters 7b, 7d and 5a provide details on what the supports and services are, but here are a few case scenarios to help you understand how you could use the resources and services:

Scenario 1:

Doug lives in a subsidized apartment for seniors and received an eviction notice for non-payment of rent. This is the 3rd time recently that Doug has called for help with the same issue, but all the other times he was able to access a different community resource for help. This time, he has been turned down and needs $168 to pay his portion of the rent, or he will be evicted. Doug admits to having problems with his neighbors and feels like his landlord does not like him. Doug is also having a hard time keeping caregivers, and the last agency he was with has recently said they can no longer serve him.

How can CTS/CTSS/WA Roads assist?

* Emergency Rental Assistance can be used to pay the $168 and prevent eviction. A CCG is used to make the payment directly to the landlord.
* Since there is a history of not paying his portion of the rent, and also some other tenancy issues with neighbors and the landlord, consider making a Foundational Community Supports - Supportive Housing referral (see [Chapter 30d](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2030d.docx) for eligibility criteria). A Supportive Housing provider could assist Doug with his longer-term housing stabilization needs as well as assist him with budgeting and possibly recommending a Payee and/or other community resources. A Supportive Housing provider may also be able to support Doug in caregiver retention strategies.

Scenario 2:

Louise has been rehabilitating in a SNF for the past year and is ready to transition into a community setting with in-home services. Louise lost her past housing due to a family situation and does not have a home to transition to. Louise meets the eligibility criteria for category 2 NED and has been offered an available voucher. Louise cannot remember the last time she held a lease in her name but does have some household items stored along with her personal belongings at a friend’s house. Since Louise has been in the SNF, she has not received any of her monthly Supplemental Security Income and does not have any money saved, nor anyone with funds that can assist her. However, Louise knows that her friend will help her move her belongings and may be able to help her with some household furnishings. Louise does not have any other friends or family that can help her with paperwork or looking for an apartment and she feels overwhelmed at the idea of managing this transition on her own. Louise also admits that she does not know where her identification is.

How can CTS/CTSS/WA Roads assist?

* Louise can be referred to work with a Community Choice Guide (CCG), who can help her complete the NED2 application packet and gather the supporting documentation. The CCG can also assist her with obtaining a new identification card, including paying the fee\*. Since Louise cannot remember her housing history and in order to prepare for the housing search, the CCG can also assist her in obtaining a Tenancy Background Screening and pay for that fee as well.
* The CCG can also assist Louise with her housing search by finding apartments and taking her to view them. Once Louise has found a unit that suits her, the CCG can assist her with the apartment application and pay the processing fee to the landlord. Once approved, the CCG can also pay the deposit and pro-rated 1st month’s rent so the client can sign the lease and get a move-in date. With her move-in date established, the CCG can also assist Louise with setting up her electricity account and paying her required $100 utility deposit since Louise has never had an account in her name.
* Louise was able to go through her stored items and she feels she has most things she needs to live independently. Her friend is helping her with a bed and dresser as well. The only basic items that Louise is missing are a lamp, bath towels and cookware. Upon CM authorization, the CCG can purchase these items for the client.
* Since Louise has not lived independently for some time, the CCG can also be tasked with helping her to create a monthly budget, and assist her in finding community resources for assistance with food and utilities. The CCG can also assist Louise in determining what bus routes are close to her for her non-medical transportation needs.

\*CCGs pay for approved items and then submit for reimbursement.

## 6.12 Community resources for housing

There are other community resources for housing that may be available to your client. The [Roads to Community Living internet site](https://www.dshs.wa.gov/altsa/stakeholders/housing-resources) contains regional information for community housing resources.

## 6.13 Resources

### **Housing** **Team Contacts can be found on the** [**RCL Housing Resources Website**](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA-Housing-Regional-Map.pdf)

**Office of Housing and Employment website:**  [Office of Housing and Employment](https://www.dshs.wa.gov/altsa/office-housing-and-employment)

**Brochures and Videos**

[ALTSA Housing Resources](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA%20Housing%20Opportunities.pdf)

[Federal Vouchers One-Pager](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Housing-Employment/FederalVouchers.pdf)

[811 Units One-Pager](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Housing-Employment/811Units.pdf)

[LTSS One-Pager](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/LTSS%20One-Pager.pdf)

[Global Leasing One-Pager](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/Global%20Leasing%20Materials.pdf)

[Zero Income One-Pager](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/Zero%20Income.pdf)

[Income Discrimination Flyer Income Discrimination Flyer Tenants: New Legal Protection from Discrimination Based on Source of Income](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/Income%20Discrimination%20Flyer.pdf)

[ALTSA Bridge Subsidy Brochure](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/ALTSA-Housing-Resource-Bridge-Subsidy-Brochure.pdf) [Governor’s Opportunity for Supportive Housing One-Pager](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/RCL/GOSH-SH-One-Pager.pdf)

[MIST Field One-Pager](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Housing-Employment/Motel-Interim-Stays-for-Transition-MIST-Field.pdf)

Video: [Options for Housing Through Long-Term Care Services](https://www.youtube.com/watch?v=wRFjTKyqWJ4)

**Related WACs:**

[WAC 388-106-0270](https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-0270): What services are available under Community First Choice (CFC)?

[WAC 388-106-0030](https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-0030): Where can I receive services?

[WAC 388-106](https://apps.leg.wa.gov/wac/default.aspx?cite=388-106): Long Term Care Services

[WAC 388-106-1700](https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-1700) to [WAC 388-106-1765](http://apps.leg.wa.gov/wac/default.aspx?cite=388-106-1765): Supportive Housing

### **Acronyms:**

|  |  |  |
| --- | --- | --- |
| HPM: Housing Program Manager | LTSS: Long-Term Services and Supports | ERA: Emergency Rental Assistance |
| GOSH: Governor’s Opportunity for Supportive Housing | FCS: Foundational Community Supports | SH: Supportive Housing |
| CCG: Community Choice Guide | SHA: Spokane Housing Authority | PHA: Public Housing Authority |
| PBV: Project Based Voucher | AMI: Area Median Income | FMR: Fair Market Rent |
|  |  |  |
| Forms: |  |  |

[GOSH Referral Form](http://forms.dshs.wa.lcl/formDetails.aspx?ID=74562)

[ERA Request Form](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Housing-Employment/ERARequestForm.pdf)

[Tips for Maintaining LTSS](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Housing-Employment/4a-Tips-for-Maintaining-LTSS.pdf)

[Bridge Subsidy Process & Referral](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Housing-Employment/4b-Bridge-Subsidy-Process.pdf)

[MIST Request Form](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/Housing-Employment/4i-MIST-Request-Form.pdf)



### **Updates to the Chapter:**

**May 2020** – Established

**August 2020** – Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs

**October 2020** – Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in “GOSH Client Accepted” section. Added Housing Team contacts under section 5b.11. In section 5b.4 added instruction on how to document ALTSA subsidy into CARE and Bridge file transition information. Added *Forms* to section 5b.11 including (2) new forms: ALTSA Bridge Referral and Bridge Referral and Application Process.

**February 2021** - Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH “Discharge Planning” and “Transition to Independent Housing” sections to 5B.5. Updated hyperlinks.

**May 2021** - Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add “Housing subsidy (HCS/AAA)” and “Supportive Housing (HCS/AAA)” as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the ‘How can I use CTS/CTSS/WA Roads section’. Updated PM Roles.

**August 2021** - Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 ALTSA HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.

**February 2022** - Updated various links throughout the chapter. Updated ALTSA Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added *What is needed to transfer an ALTSA subsidy client from HCS to the AAA?* Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).

**August 2022** – Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from ALTSA housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: [What is the Governor’s Opportunity for Supportive Housing?](https://youtu.be/DTAvZlmM1pQ); [You’ve Been Referred to GOSH – Now What?](https://www.youtube.com/watch?v=DyCerTNs2ZU); [Governor’s Opportunity for Supportive Housing (GOSH): Good Discharge Planning](https://youtu.be/z5BKwZY7F1U)

**November 2022 –** Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on ALTSA Housing Resources who are not currently receiving LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.

**February 2023** – Updated Unit Manager titles. Updated “NED” section to “permanent HUD voucher” section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version ALTSA Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.

**May 2023** - ALTSA subsidy video link. Updates to Section 5b.5. Updated ERA form.

**August 2023** - Updated information in the ALTSA Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.

**November 2023** – Updated Emergency Rental Assistance Form. Clarified language and updated language in section [5b.5](#_Background) “Working with individuals on ALTSA housing resources who are not currently receiving ALTSA LTSS”. Updated GOSH Section to include new regional referral email addresses.

January 2024-Chapter Links added and updated ERA form added

February 2024- Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible ALTSA clients who are already enrolled in a housing service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 ( 1 d. and the HCS/AAA CM will extend the WA Roads RAC) & ( 2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements “while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used.”

3/27/2024- Updated Bridge documents at bottom of document with most recent versions. Page 11 &12 amended for ALTSA Bridge Subsidy.

5/7/2024- Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.

6/17/2024- added ERA email address. Updated ERA referral process. Removed “How do I make a referral for a client who I believe is eligible for ERA?” Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated & added “How is payment made for MIST?” process/procedure. Updated MIST Referral Form.

9/3/2024- Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how ALTSA pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.

November 2024- Added information regarding the ALTSA Acute Care Hospital Subsidy, and the referral/process and referral.