Housing & Service Coordination

Chapter 6D provides guidance on working with clients experiencing homelessness, documenting housing resources in CARE, and effectively pairing Long-Term Services and Supports (LTSS) with housing assistance. This chapter outlines when the LTSS RAC can be used to authorize Goods & Services for clients accessing housing resources through HCS. Additionally, it covers best practices for integrating supportive services with housing solutions and highlights community-based housing resources that can further assist clients in achieving long-term stability.

Ask the Expert

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For additional information please visit our website: Office of Housing and Employment

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BACKGROUND

The HCS Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around Housing and Urban Development (HUD) permanent federal vouchers and can help you refer clients who are eligible for them.

Whenever possible, we can offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like to see addressed in this chapter.

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: What services are available under community first choice (CFC)?

WAC 388-106-0030: Where can I receive services?

> The Challenging Cases Protocol can also be used, and is often necessary, when working with clients who are experiencing homelessness. See Chapter 5 for more information.

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.
- Consider eligibility for FCS-Supported Employment.
- If the client has access to any housing opportunities and is not FCS-SH eligible, consider authorizing a Community Choice Guide through Roads to Community Living, COPES or a state-funded service package LTSS Housing Stabilization or WA Roads.
- If the client has behavioral challenges that are affecting the establishment of LTSS, consider making a Behavioral Supports H2019 (Chapter 5a) referral.
- If a client is initially declining personal care services, it is allowable to use the COPES Wellness Newsletter 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 and consider contacting your regional HPM to see if they are aware of any resources that may be available.
- Also see Community Resources for Housing.

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

Some clients experiencing homelessness go through the HCS 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.

DOCUMENTING HCS HOUSING RESOURCES IN CARE

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

It is important to document that your client will receive an HCS 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 HCS 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 HCS Subsidy, the HCS CM must enter the following into the CARE assessment:

- Add “Housing subsidy (HCS/AAA)” as a Treatment for HCS Bridge and HCS 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 HCS 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 on 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).

HOUSING & EMPLOYMENT STABILIZATION SERVICES

For HCS clients who are found functionally and financially eligible for LTSS, **and** have received a housing resource or had their housing coordinated through HCS; **or** enrolled with Supported Employment or had their employment coordinated through HCS; **and**:

- Transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home or are living in the community and need stabilization services to remain there, and
- Does not have other programs, services, or resources to assist them with these costs, and
- Is not eligible for federal funding:

1. Use Service Code SA294,U4 (Housing Subsidy-Purchasing) to authorize the necessary goods and services (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, or/and assistive technology) needed to transition or/and stabilize the client safely back to the community. Please note, an ETR will be required if the total amount of goods & services exceeds $5000.
2. Select the appropriate reason code. Options are "In-Home Community Stabilization" or "Employment Stabilization"
3. When submitting an ETR, select "other" for both ETR/ETP category and type.

4. Submit the ETR for approval/denial to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR request.
5. Note in the Service Episode Record (SER) that the client is eligible for Housing & Employment Stabilization services and that you have Supervisory approval to authorize state only funds.
6. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
7. Receipt(s) or/and invoice(s) for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615).

PAIRING SERVICES WITH HOUSING RESOURCES

Whether a client is using an HCS 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 HCS recipients:

- Individuals who are currently residing in the community may be eligible for Supportive Housing services under "Healthier Washington Medicaid Transformation: 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 Chapter 6E.

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. HCS 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 that program, please see Chapter 30d.

How do I use Community Transition Services (CTS) or Housing & Employment Stabilization services to assist my client with a housing resource?

Clients may access HCS CTS and H&ES, 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.
- Community Transition Services (CTS) through COPES, see Chapter 7d.
- Community Transition Services (CTS) through Roads to Community Living (RCL), see Chapter 29.
- Housing & Employment Stabilization Services through RAC 3131- LTSS Housing Stabilization is for clients that are only eligible for state funding and have an HCS subsidy or are enrolled with Supported employment. All goods and services can be authorized using service code SA294,U4.
- 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.

Please note that individuals who are receiving an HCS Housing Resource are immediately eligible for Housing & Employment Stabilization Services and the goods and services it provides.

All clients active on LTSS and receiving an HCS Housing Resource (NED, 811, HCS Subsidy) have access to transition/stabilization services through the duration of their subsidy. Clients can access CTS/Housing & Employment Stabilization Services 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, COPES, and Roads to Community Living services are always the priority programs for transition services. Housing & Employment Stabilization 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 and 7d 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/Housing & Employment Stabilization Services?

- 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 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 who 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/Housing & Employment Stabilization Services?

- 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 Report 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 helping 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.

Coordinated Personal Care (CPC)

Background

Due to ongoing caregiver workforce shortages, some clients experience delays in accessing authorized personal care services. Historically, these delays created significant risk for clients who require assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Coordinated Personal Care was developed as a pilot program to address these service gaps. The program focuses on accelerating access to care by coordinating available caregiving resources and implementing alternative service strategies when standard provider matching is not immediately available. CPC ensures continuity of care while longer-term service arrangements are being secured.

Program Overview

Coordinated Personal Care is a client-centered service model designed to provide greater flexibility and responsiveness in care delivery. Care providers are assigned to specific geographic areas, enabling them to serve multiple clients within a defined service radius. This approach, combined with collaboration between dedicated care providers and building staff, supports more reliable and coordinated caregiving in historically hard-to-serve locations. For more information on CPC please click here.

What if a client is receiving a housing service but declining personal care?

A client must continue to meet functional (and financial) eligibility. If a client declines personal care and does not want to have a paid personal care provider (to include remote caregiving), the client's assessment must accurately reflect the client's chosen status of "Client Declines" which means "the client will not want assistance with the task".

- Please see the LTC Manual Chapter 3 for information on scoring status.
- Minimum Standards listed in LTC Manual Chapter 3 must be met, especially when transferring a case from one office to another.

When a client declines personal care, this can cause the client to be found functionally ineligible for Long-term service and supports. Case Managers are required to offer all services a client is eligible for and inform them of what declining personal care may mean for their Medicaid medical benefits and home and community-based services and supports, including the client losing their housing subsidy.

Guidance for when a client is declining personal care

When individuals become ineligible and inactive from LTSS, they may only retain their subsidy through the end of their current lease terms. The following steps can be tried to support the client in remaining eligible for LTSS so that they can keep their subsidy.

Work with the client and others on their support team and, when appropriate, inform the team of the client's decision to decline personal care.

1. **Gather collateral information** on how the client functions and what informal or unpaid support they are receiving and ensure it is coded accurately in the assessment. See the Assessing Status (Informal Supports) section of LTC Manual Chapter 3.
2. **Utilize another service provider** who may have a different relationship with the client to discuss the situation with them.
3. **Consider whether the client is in crisis or decompensating.** Give the client time and opportunity to access other services to support a return to their baseline, when possible.

Offer **all services** the client is eligible for.

Make sure **LTC Manual chapter guidelines** are followed for the benefit package the client is functionally and financially eligible for and enrolled in. For the benefit packages below, clients may receive a service or item they are eligible for, with or without personal care services authorized. **Please note, this does not apply if the client is declining personal care services.**

- Community First Choice (CFC), LTC Chapter 7b states a CFC client may receive any CFC service or item they are eligible for, with or without personal care in place.
    - A **CFC** client who is eligible for and needs/wants a PERS unit, does not need to be authorized for personal care services to receive the CFC benefit of PERS service.
    - Please note, when a client is assessed next, the client must meet functional eligibility by having an unmet or partially met need with at least three of the ADL task(s) listed in WAC 388-106-0355 in order to continue to receive CFC services for the next CARE plan.
- When an individual is found eligible for CFC+**COPES**, there are many additional COPES waiver services a client can choose from that are found in Chapter 7d.
    - As an example, a COPES eligible client can choose to receive the Wellness Newsletter if they are eligible and do not need to be authorized for personal care services to receive the waiver benefit.
- Roads to Community Living (**RCL**) Chapter 29
    - Individuals who are enrolled in **RCL** have many service options beyond personal care and can be found in the chapter link.
    - If you are working with a client who is on **RCL**, please contact an **RCL** Enrollment Specialist prior to inactivating services. DSHSALTSARCLReferrals@dshs.wa.gov
- If the individual is Medicaid Personal Care (**MPC**) eligible, as this LTSS program is limited to personal care services (see Chapter 7c), a client who is not declining personal care may access services through a state-funded benefit package. Examples include:
    - Community Choice Guide through Housing Stability RAC 3131
    - GOSH Supportive Housing Service
    - Client Training: Behavior Support through WA Roads (RAC 3120)

Offer **Remote Caregiving** when and where available.

The delivery of personal care services, using remote caregiving assistance, can be used for tasks that don't require hands-on assistance, stand-by, and/or physical set-up, alone or in combination with an in-person caregiver.

- Remote Caregiving SharePoint
- DSHS Remote Caregiving Website
- For questions RemoteCaregiving@dshs.wa.gov

Staff client's case with supervisor and utilize **Targeted Case Management** in Chapter 5**.**

Contact the Housing Program Manager for assistance.

Use the **Challenging Cases Protocol** in Chapter 5.

The purpose of the Challenging Cases Protocol is to promote statewide consistency in working with complex clients before denying or terminating services. Service termination does not abdicate standard case management practice. The protocol recognizes the client's preferences of care, services, and life choices. Every effort must be made toward resolution of issues that may lead to denial or termination of services.

Staff the situation in either a Complex Care Case Staffing meeting or the **Housing Supports Case Staffing** meeting.

For an invitation to the Housing Supports Case Staffing meeting. Please contact your regional Housing Program Manager.

If the client's assessment is in current status, and the client decides they do not want to receive personal care (declines personal care), do I need to complete another assessment?

If a client declines personal care and does not want to have a paid personal care provider, the client's assessment must accurately reflect the client's chosen status of "Client Declines" which means "the client will not want assistance with the task". An interim assessment is used to report information about the client that is **not** related to a change in the client's condition.
See LTC Manual Chapter 3, *When do I perform an interim assessment?,* for more information.

If a client declining personal care results in them being ineligible for LTSS, a Significant Change assessment must be completed prior to inactivating the case. See LTC Manual Chapter 3.

Steps to follow when the AAA sends a case back for no personal care services authorized.

- **Make sure file meets minimum requirements** for transfer per Chapter 3.
  - Clients are not required to have a personal care authorization to be transferred and case managed by the AAA. (see chapter 3)
- **Follow Transfer Protocol** per Chapter 5.

- **Consider a case staffing amongst offices**. If needed, escalate to the appropriate HQ expert listed in chapters 3 or 5.

Follow the process of **terminating** services.

- See Chapter 3 of LTC Manual.

Follow **best practices** in documentation.

- See Chapter 5 of the LTC Manual.
- See Chapter 27 for Notices

HOW DO I EXIT A CLIENT WHO HAS AN HCS SUBSIDY BUT IS NO LONGER ELIGIBLE FOR LTSS?

- The HCS/AAA case manager will communicate the following to the client "Due to your Long-Term Services and Supports being terminated, your housing subsidy/rent assistance is also being terminated at the end of your current lease. You will then be responsible for the full rent amount."

- The HCS/AAA case manager will hold the case for up to 90 days from the date the client is no longer eligible for services.
    - If the client cannot afford the full rental amount without subsidy support, this transition period allows time to identify and secure affordable housing, apply for alternative programs, and coordinate relocation as needed. This process helps prevent housing instability and reduces the risk of homelessness prior to case closure.
    - If the client has a GOSH provider, they can continue working with the client for the 90-day period to work on alternatives. Please see Chapter 6E for more information, including guidance on GOSH termination PANs.
    - If the client wants support in finding housing alternatives, a Community Choice Guide (CCG) can be authorized for 90 days through RAC 3131- LTSS Housing Stabilization. Since the HCS subsidy is a state paid service, no PAN is required. Please reach out to HPM to notify them that the client will become inactive.
    - The HCS/AAA case manager will offer the client alternatives (Foundational Community Support referral, resource list, etc.).

- The HCS/AAA Case manager will notify the assigned Housing Program Manager when the client has been found not eligible for services.

- The HCS/AAA will need to verify that all Contracted Providers working with the client have been reimbursed before inactivating the case.

- 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.

WHEN CAN A CLIENT'S HCS SUBSIDY BE TERMINATED?

- When they refuse to complete an Initial, Annual or Significant Change CARE Assessment, or
- They do not meet functional and/or financial eligibility for HCS Long-Term Services and Supports, or
- They decline personal care services, or
- They refuse to apply for an available permanent housing voucher or other permanent affordable housing, including waitlists, in their area, or
- They are absent from your HCS-subsidized unit for more than 180 continuous days, or
- They do not allow the required, biannual housing inspection, or
- They no longer live in their unit, or
- Their actions have created an unsafe or illegal situation in their subsidized unit, or
- They accept a different subsidy or move into a permanently subsidized apartment.

HOUSING RESOURCES THROUGH CIVIL TRANSITIONS

Yes, a Civil Transitions Program recipient can access a specific housing resource through HCS. Participants in the Civil Transitions Program are eligible for HCS housing resources regardless of LTSS eligibility status. The Civil Transitions Program relates to individuals deemed by the court not competent to stand trial and not restorable due to a diagnosis of dementia, traumatic brain injury (TBI), or an intellectual or development disability (IDD).

Eligibility Criteria:

A Civil Transitions Program recipient that is referred to a housing resources, is eligible to access a housing resource without having to be functionally, or/and financially eligible for LTSS.

Which housing resources can a Civil Transitions Program Recipients Access:

They can access the following resources:

- Motel Interim Stay for Transitions (See Chapter 6B)
- Housing and Employment Stabilization Services (See Chapter 6D)

- Supportive Housing Services (see Chapter 30D)

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 contains regional information for community housing resources.

Additional Housing Resources are available for clients. Please visit Housing Openings to learn about waitlist openings for Project Based/ Mainstream/Housing Choice Vouchers.

RESOURCES

Housing Team Contacts

Office of Housing and Employment SharePoint

HCS Housing Resources

Federal Vouchers One-Pager

811 Units One-Pager

LTSS One-Pager

Global Leasing One-Pager

Civil Transitions Program One-Pager

Zero Income One-Pager

Income Discrimination Flyer: Legal Protection from Discrimination Based on Tenant's Source of Income

HCS Bridge Subsidy Brochure

Governor's Opportunity for Supportive Housing One-Pager

MIST Field One-Pager

Video: Options for Housing Through Long-Term Care Services

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stays for Transitions (MIST) SA294u1

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. 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 up to a 6-month period. Federal MIST is funded via the 1115 waiver in which the Washington State Health

Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.	
Who is eligible for federal MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **HCS Subsidy (Bridge or Acute Care Hospital)** • Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. Client must be required to leave their SNF for non-medical reasons; Bridge clients cannot choose to leave their SNF in order to utilize a MIST funded hotel. • Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • HCS 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, HEN, HOPWA, VASH, etc. • HCS clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** HCS 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. 5. **Experiencing Homelessness**: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	1. Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel.
What is not covered under MIST 294u1?	1. Deposits 2. Damages (Please see RAC 3131 SA294,U2)
How much can I spend?	1. Up to $5,000 per month for a total of six months. • Note: not to exceed six months

Do I need to use a Community Choice Guide (CCG) or GOSH provider?	**Yes.** 1. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. 4. The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize federal MIST payments?	1. Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3132. 2. For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. 3. If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	**No.** 1. When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS 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. Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs (HRSN) Services Program will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.	
Who is eligible for federal ERA?	1. An HCS or AAA client who is experiencing or at risk of experiencing homelessness, including facing immediate eviction due to non-payment of rent.

What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an HCS or AAA client who is facing an immediate eviction due to non-payment of rent. 2. Late fees can be included.
What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs. 2. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent. 3. Any fees other than late fees.
How do I make payment?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client's behalf.
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	**No.** 1. Note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who are choosing In-Home setting and: 1. Are willing to work with a Supportive Housing Provider, **and** 2. qualify for HCS services (financially & functionally eligible), **and** 3. are discharging or being diverted from Eastern or Western State Hospitals. 4. 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.

	5. HCS 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 the State Hospital Discharge and Diversion (SHDD) team, and wish to live independently.
What is covered under GOSH SA299,U1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: 1. Screening and housing assessment for individual's preferences and barriers. 2. Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. 3. Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. 4. Identifying resources for modifications and/or one-time move-in needs. 5. Assisting in arranging for and supporting details of moving into housing. 6. Training on roles, responsibilities, and rights of tenant and landlord. 7. Developing housing support crisis plan. 8. Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in "Service Standards for Providers."
What is not covered under GOSH SA299u1?	1. Rent 2. Move-in costs 3. Utilities
How much can I spend?	1. 160 units per month
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM: 1. 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. 2. It is the SHPM's responsibility to open, extend and close authorizations for service code SA299, U1.
When do I authorize this service?	1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	**No.**

What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b). 2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code "Civil Transitions Program". 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,U1 authorization, then: ○ Open RAC 3131 LTSS Housing Stabilization ○ Open SA299,U1 and use Reason Code "5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Governor's Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor's Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting **and**: 2. Are willing to work with a Supportive Housing Provider, **and** 3. Qualify for HCS services (financially & functionally eligible), **and** 4. Are discharging or being diverted from Eastern or Western State Hospitals. 5. 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. 6. HCS 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.
What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc. 2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs

	3. Utilities
How much can I spend?	1. 1 unit per month (rate $575)
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	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. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 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.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. 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. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP's contract.
Are ETRs allowed for GOSH H0044?	**No.**
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use Reason Code "5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Motel Interim Stays for Transitions (MIST) SA294u2

Motel Interim Stays for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. 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 up to a 6-month period.	
Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **HCS Subsidy (Bridge & Acute Care Hospital)** • Bridge Subsidy: HCS clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: HCS clients transitioning from an Acute Care Hospital (ACH) setting~~,~~ when housing is a barrier. 2. **GOSH Program:** HCS clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • HCS 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, HEN, HOPWA, VASH, etc. • HCS clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement**: HCS 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. 5. **Experiencing Homelessness**: HCS clients experiencing homelessness, at risk of homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u2?	1. Payment for up to 6-month period for a Medicaid HCS client to stay at a motel/hotel. 2. Deposits. 3. Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager).
What is not covered under MIST 294u2?	1. Monthly payment that exceeds $4,000.
How much can I spend?	1. Up to $4,000 per month for a total of six months.
Do I need to use a Community Choice Guide (CCG) or GOSH Provider?	**Yes.** 1. The HCS/AAA CM will need to coordinate with the CCG or GOSH provider and notify them that the client has been authorized for Motel Interim Stays for Transitions for a period of up to 6 months.

	2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. 4. The CCG or GOSH provider can make payments, or Spokane Housing Authority can be authorized to make payments.
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM will receive an approval email with specific instructions. should open RAC 3131. 2. For instructions on how to authorize MIST payments, please see the MIST Authorization Desk Guide. 3. If you are using Spokane Housing Authority to make the MIST payments, please see the MIST Guide for Spokane Housing Authority Payments. 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select "2017 Governors Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for state MIST?	**No.** 1. Note: When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES). These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients who have received a housing or Supported Employment resource or had their housing/employment coordinated through HCS to sustain community living.	
Who is eligible for state H&ES?	When an HCS client meets these qualifications: 1. Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; **or** 2. Is found functionally and financially eligible and enrolled with Supported Employment or had their employment coordinated through HCS; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own

	home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist them with these costs; **and** 5. Are not eligible for federal funding.
What is covered under state H&ES?	Goods necessary to establish a residence such as essential household furnishings. 1. Items needed to help stabilize community living for a client. 2. Packing assistance. 3. Moving assistance. 4. Utility set-up fees or deposits. 5. Non-recurring health and safety assurances such as pest eradication, allergen control and/or extreme cleaning. 6. Rental deposits: all pre-tenancy payment requirements, including first month's rent, can be bundled as one deposit and reimbursed to a Community Choice Guide or a DSHS contracted Supportive Housing provider.
What is not covered under state H&ES?	1. Recreational or diversional items such as television, cable or DVD players. 2. Assistive Technology.
When do I need a provider contract?	1. A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	1. Open RAC 3131-LTSS Housing Stabilization. 2. Use Service Code SA294,U4 to authorize the necessary goods and services. 3. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization" 4. Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. 5. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. 6. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615), prior to sending to DMS.
When do I authorize this service?	When an HCS client meets these qualifications: 1. Is found functionally and financially eligible and received a housing resource or had their housing coordinated through HCS; **or**

	2. Is found functionally and financially eligible and enrolled with FCS Supported Employment or had their employment coordinated through HCS; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to their own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist them with these costs; **and** 5. Are not eligible for federal funding.
Are ETRs allowed for state H&ES?	**Yes.** 1. An ETR will be required if the total amount of goods & services exceeds $5000. 2. Select "other" for both ETR/ETP category & type. 3. Submit the ETR to "Committee, Housing ETR" 4. Note: If the amount Exceeds $2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an HCS 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.	
Who is eligible for state ERA?	1. An HCS client who is facing immediate eviction due to non-payment of rent.
What is covered under state ERA?	1. A one-time payment made directly to landlords on behalf of an HCS client who is facing an immediate eviction due to non-payment of rent. 2. Late fees. 3. Other fees that are tied into the lease where client is at risk of eviction if they are not paid.
What is not covered under state ERA?	1. ERA does not include pre-tenancy deposits or move-in costs, including first month's rent.
How do I make payment?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide, GOSH Supportive Housing Provider, or Spokane Housing Authority) to make the ERA payment on the client's behalf.

How do I authorize state ERA?	1. Upon approval, the Housing Program Manager will provide instructions to authorize payment to a CCG or GOSH provider. 2. To authorize payment for Spokane Housing Authority, please see the ERA-SHA Reimbursement Guide.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA CM is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	**Yes.** 1. When the ERA request amount is above $4000, this will generate an error message in CARE that will require the HCS/AAA CM to reach out to the Housing Program Manager to request an ETR and force the error. There is no formal ETR request process.

Community Choice Guide SA263

Payment for specialty services which provide assistance and support to ensure the eligible client's successful transition to the community and/or maintenance of independent housing as authorized by HCS and/or AAA staff.

CCG services may include but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers when applicable.
- Maintaining or assisting with obtaining affordable housing.
- When relevant, liaising among and with the client, nursing or institutional facility staff, case managers, housing providers (including AFH providers), medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved party.
- Necessary assistance to support the client's community living, including assistance in settling disputes with landlord.
- Educating client on tenant rights, expectations and responsibilities.
- Assisting client with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- Assisting client with locating and arranging transportation resources to effectively connect with community resources.
- Assisting client to locate and engage community integration activities.
- Training or education to client about accessing community settings or health services.
- Assisting client with finding a qualified caregiver.

Detailed instructions on how to make a CCG referral using Service Codes SA263 can be found in the Chapter 7d: COPES of the LTC Manual.

The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in Chapter 29: Roads to Community Living.

Related WACs:

WAC 388-106-0270: What services are available under Community First Choice (CFC)?

WAC 388-106-0030: Where can I receive services?

WAC 388-106: Long Term Care Services

WAC 388-106-1700 to WAC 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

Tips for Maintaining LTSS

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2020		Established	
8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	

10/2020		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 HCS subsidy into CARE and Bridge file transition information. Added *Forms* to section 5b.11 including (2) new forms: HCS Bridge Referral and Bridge Referral and Application Process.	
2/2021		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.	
5/2021		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.	
8/2021		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 HCS HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated HCS Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added *What is needed to transfer an HCS 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).	
8/2022		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 HCS 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?; You've Been Referred to GOSH – Now What?; Governor's Opportunity for Supportive Housing (GOSH): Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on HCS 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.	
2/2023		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 HCS Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	
5/2023		HCS subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the HCS Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on HCS housing resources who are not currently receiving HCS LTSS". Updated GOSH Section to include new regional referral email addresses.	
1/2024		Chapter Links added and updated ERA form added	

2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible HCS 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 HCS 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	Joana	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 HCS 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.	
10/2024	Joana	Chapter 5b changed to Chapter 6. Chapter 6 Established	
11/2024	Joana	Added information regarding the HCS Acute Care Hospital Subsidy, and the referral/process and referral.	
01/2025	Joana	Edited information regarding the HCS Acute Care Hospital Subsidy	
03/2025	Joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6D- Housing & Service Coordination established. Update policy & procedure regarding Housing and Employment Stabilization Services. Updated OHAE background and EDAI statement. Added a chart describing all the RACs and Service Codes associated with OHAE. Added information regarding the Civil Transitions Program and relation to Housing Resources.	
07/2025	WJH	Removed Whitney Joy Howard under "ask the expert" section; Through chapter changed language that referenced "ALTSA" to "HCS"; Added in section on use of Housing & Employment Stabilization Services (SA294u4); Added in a section on the Civil Transition Program housing resources; Added information on RCL and HRSN STRA and how it is used in combination with state dollars to support a client's interim HCS Subsidy.	
9/2025	Jonnie	Added section on How to Work with Clients Declining Personal Care.	
03/2026	Joana	Added section how to work with a client who is declining pc. Added section regarding how a client can lose their HCS Subsidy. Added section on how to exit a client from the HCS Subsidy	
04/2026	Jonnie	Remove funding chart. Updated information regarding SA294,U4.	
07/2026	Tom	Added information to the Q&A section regarding Spokane Housing Authority making payments for MIST and ERA.	