NewYork-Presbyterian
Performing Provider System

THE BRONX HEALTH & HOUSING CONSORTIUM

Completing the HRA 2010e and Preparing Clients for Housing Interviews

April 12, 2019

Housing Instability Webinar Series

Part 1: The Intersection between Health and Housing	Wednesday, November 14, 2018	Click here to view webinar
Part 2: Navigating the Shelter System	Wednesday, December 12, 2018	Click here to view webinar
Part 3: Permanent and Supportive Housing	Wednesday, January 16, 2019	Click here to view webinar
Part 4: Affordable Housing	Wednesday, January 30, 2019	Click here to view webinar
Part 5: Eviction Prevention	Wednesday, February 20, 2019	Click here to view webinar

NewYork-Presbyterian
Performing Provider System

Developed in partnership with 1199SEIU Training and Employment Funds

THE BRONX HEALTH & HOUSING CONSORTIUM

Learning Objectives

Attendees will be able to:

- Assess patients for eligibility for supportive housing using the CAPS survey
- Complete supportive housing applications (including psychosocial assessments)
- Describe how to prepare their patients for housing interviews

Defining Supportive Housing

Targets households with barriers

Is affordable

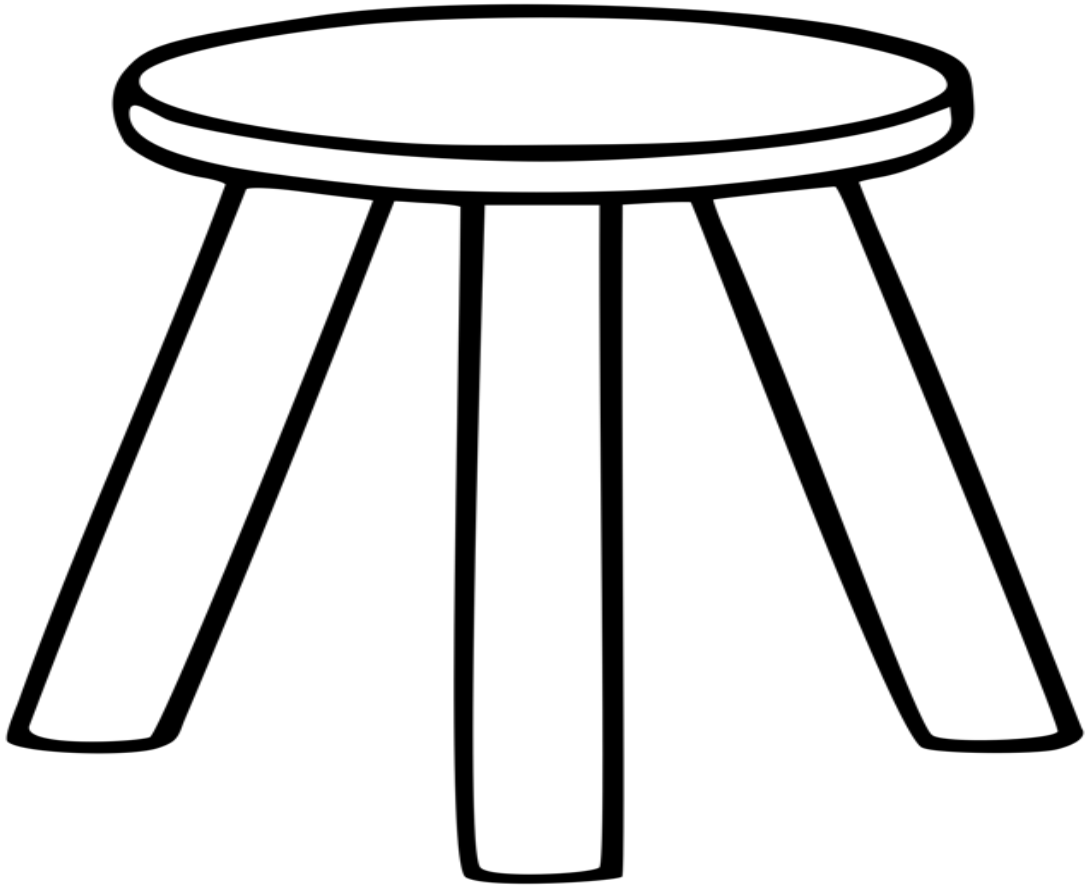
Provides tenants with leases

Engages tenants in voluntary services

Coordinates among key partners

Connects tenants with community

Financing Supportive Housing:
The “three-legged stool”



Capital

Services

Operating

Glossary

- ACS: Administration for Children's Services
- COD: Co-occurring disorder (2 or more of substance use, mental health, physical, or cognitive disorders)
- CR/SRO: Community Residences/Single Room Occupancy
- DHS: New York City Department of Homeless Services
- DOH: State Department of Health
- DOHMH: City Department of Health & Mental Hygiene
- DV: Domestic Violence
- DYCD RHY: Dept. of Youth and Community Development – Runaway Homeless Youth
- HASA: New York City HIV/AIDS Services Administration
- HH: Health Home
- HCR: State Department of Homes & Community Renewal
- HDC: New York City Housing Development Corporation
- HOPWA: Housing Opportunities for Persons with AIDS
- HRA: New York City Human Resources Administration
- HUD: U.S. Department of Housing and Urban Development
- MCO: Managed Care Organization
- MICA: Mentally Ill and Chemically Addicted
- MLTC: Managed Long-Term Care
- MRT: Medicaid Redesign Team
- OASAS: State Office of Alcohol and Substance Abuse Services
- OHS: Olmstead Housing Subsidy
- OMH: State Office of Mental Health
- OPWDD: State Office of People with Developmental Disabilities
- OTDA: State Office of Temporary and Disability Assistance
- PPS: Performing Provider System
- RTHP: Rapid Transition Housing Program
- SH: Supportive Housing
- SMI: Serious Mental Illness
- SNF: Skilled Nursing Facility
- SPMI: Serious & Persistent Mental Illness
- SSVF: Supportive Services for Veteran Families
- SUD: Substance Use Disorder
- VA: U.S. Department of Veteran's Affairs

Supportive Housing

NY/NY I, II	• Affordable housing tied with supportive services for SPMI, street or shelter homeless • Accessed through CAPS HRA 2010e application
NY/NY III *(Scattered-site & Congregate)*	• Affordable housing tied with supportive services • Accessed through CAPS HRA 2010e application
	• Population A: Chronically homeless single adults who suffer from a serious mental illness or who are diagnosed as mentally ill and chemically addicted (MICA). • NYC HRA
	• Population B: Single adults who are presently living in NYS-operated psychiatric centers or State-operated transitional residences and who could live independently in the community if provided with supportive housing and who would be at risk of street or sheltered homelessness if discharged without supportive housing. Effective December 6, 2013, eligibility is expanded to include: single adults designated as “nursing home remedy members” who were living in a NYS-operated psychiatric center or State-operated transitional residence immediately prior to their current nursing home placement and are at risk of homelessness if discharged without supportive housing. • NYS OMH
	• Population C: Young adults with SMI or Severe Emotional Disturbance who are at risk of homelessness • NYS OMH

Supportive Housing

NY/NY III *(Scattered-site & Congregate)*	• Population D: Chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of the household suffers from a serious mental illness or a MICA disorder. • NYC HRA
	• Population E: for chronically homeless single adults who have substance abuse disorder (SUD) that is primary barrier to independent living and who also have a disabling clinical condition (non-SPMI) that further impairs their ability to live independently. • NYC HRA
	• Population F: for homeless single adults who've completed a course of treatment for substance abuse disorder and at-risk for street/ shelter homelessness • NYC HRA
	• Population G: for chronically homeless families or families at risk of chronic homelessness in NYC in which the head of household has a substance use disorder, a disabling medical condition, or HIV/AIDS. • NYC HRA
	• Population H: for chronically homeless single adults who are living with HIV/AIDS (clients of HASA) and suffer from co-occurring SMI, SUD • NYC HRA/HASA
	• Population I: Young adults aging out of foster care who are at risk of homelessness • NYC ACS

Supportive Housing

Shelter + Care → Continuum of Care (CoC) Program	• Provides rental assistance with supportive services for homeless and disabled persons and their families. • For homeless persons with disabilities, (SMI, SUD, AIDS or related diseases) and their families who are living in places not intended for human habitation
Supported /Single Room Occupancy *(Congregate)*	• Permanent housing in SRO buildings. Chronically homeless single adults diagnosed with SPMI or diagnosed as mentally ill and may also have a substance use disorder. • NYC – DOHMH, DHS, HRA/HASA; • NYS – OMH • HRA 2010e applications required for special needs tenants only
Supported *(Scattered-site)*	• Permanent, independent level of housing. Clients pay 30% of their income towards rent and utilities and hold own lease or provider's sublease • NYS OMH

Supportive Housing

Re-Entry PSH Initiative (*scattered-site)*	• Provides rental subsidies up to Fair Market Rental rates, case management, job development and job counseling services to parolees returning to their communities. • Eligible person must have substance abuse problems and being released on parole to NYC and would be functionally homeless if not placed in this PSH program. • NYC only – OASAS
HOPWA	• Housing Opportunities for Persons with AIDS (HOPWA): provides housing assistance and related supportive services for low-income (at/ below 80% AMI) persons living with HIV/AIDS (PLWHA) and their families. • NYC – DOHMH, HRA/HASA
HASA	• Homeless individuals diagnosed with an HIV/AIDS diagnosis or homeless families that include individuals living with HIV/AIDS. • NYC – HRA/HASA

Supportive Housing

Sect. 811	• Allows persons with disabilities to live as independently as possible with rental assistance • 18+; Single qualified person with very low (50% AMI) and physical or developmental disability or chronic mental illness • HUD
Consolidated Supports and Services (CSS)	• Housing subsidy for individuals able to live independently, apply 30% of income toward housing costs prior to making a request for subsidy. • OPWDD
Individual Supports and Services (ISS)	• Subsidy based on an individual's income and Housing and Community Renewal (HCR) payment standards. Historically, assisted adults with DD who wish to live independently by providing funds to pay for housing costs, and on a limited basis, for such things as food, transportation and clothing • OPWDD

Supportive Housing

HUD VASH	• Permanent housing via "Housing Choice" Section 8 vouchers for eligible homeless single Veterans or eligible homeless Veterans with families. Clinical and supportive services provided through VA. Vets must meet McKinney Act "homelessness" definition. Restrictions based on discharge status • To apply contact local VA Homeless Program. Vets can contact HUD-VASH program directly, or obtain a referral
Supportive Services for Veteran Families Program (SSVF)	• Short-term rapid rehousing and homeless prevention services to homeless and at-risk Veterans and their families • VA, non-profit, CBOs
Section 202	• Supportive Housing for the Elderly program (Section 202) provides rent subsidies to make units affordable for very low-income household comprised of at least one person who is at least 62 years old • Project-based Section 8 applied to directly to residences • Housing options for seniors
Access to Home	• Access to Home program to provide home modifications (i.e. ramps, lifts, handrails, etc.) to high cost Medicaid members. Such modifications would enable these individuals to remain in their homes or transition back to their homes. • NYS HCR • https://hcr.ny.gov/access-home-medicaid-recipients

Supportive Housing

Medicaid Redesign Team (MRT) *(Scattered site & Congregate)*	Invests into housing as a social determinant of health to improve the quality of care to the vulnerable Medicaid population. MRT provides funding for rental subsidies, support services and capital projects. https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing_initiatives.htm	
	DOH Olmstead Housing Subsidy (OHS)	• Statewide program that provides rental subsidies and community transitional services for seniors and adults with chronic disabilities who are homeless, have spent at least one hundred and twenty (120) consecutive days in a skilled nursing facility over the most recent two–year period, and can live safely in the community. • https://ilny.us/programs/olmstead-housing-subsidy-ohs
	DOH Rapid Transition Housing Program (RTHP)	• Previously known as Nursing Home to Independent Living) • Provides a rental subsidy and supportive housing services for high-need Medicaid beneficiaries. The program is available in four areas of the state: Long Island, Syracuse, New York City and Rochester. • Eligibility: individuals who are either currently enrolled in the program or are individuals with one or more documented chronic physical disabilities and have two or more chronic conditions (e.g., asthma, diabetes, substance abuse disorder (SUD)). Participants in the program must be on Medicaid and referred as homeless high-utilizers by a hospital, Managed Care Organization (MCO), medical respite, Performing Provider System (PPS), or skilled nursing facility (SNF). • https://ilny.us/programs/rapid-transition-housing

Supportive Housing

Medicaid Redesign Team (MRT) *(Scattered site & Congregate)*	AIDS Institute Rental Subsidies and Service Supports	• Long–term tenant based rental assistance and supportive housing services for homeless or unstably housed, Health–Home–enrolled, HIV+ individuals. Supportive housing counselors help recipients locate and maintain housing and learn Health and Independent Living Skills. • https://www.health.ny.gov/diseases/aids/general/about/housing.htm
	OMH Rental Subsidies	• Housing rental subsidies and case management for up to 350 units statewide and 350 units in Brooklyn for single adults with a serious mental illness. • OMH Adult Housing
	OASAS Rental Subsidies and Supports	• Statewide rental subsides and service supports for single adults who are high–cost Medicaid participants, chronically addicted, and homeless or at risk of becoming homeless. Services include intensive case management, job development and counseling services and clinical supervision of direct service staff. • https://www.oasas.ny.gov/housing/initiatives/MRT.cfm
	OPWDD Rental Subsidies and Supports	• Community-based housing options to relocate individuals with developmental disabilities currently living in certified settings into more independent, less restrictive housing settings (e.g. non-certified housing alternatives with supports as well as other evidenced based models and partnerships in housing alternatives) • https://opwdd.ny.gov/opwdd_resources/procurement_opportunities/request-for-new-services

Supportive Housing

Medicaid Redesign Team (MRT) *(Scattered site & Congregate)*	OTDA Homeless Senior and Disabled Placement Pilot Project	• Rental subsides for elderly or disabled SSI recipients living in NYC homeless shelters who are Health–Home eligible or require nursing home level of care. • http://otda.ny.gov/programs/housing/
	OTDA NYC Disability Housing Subsidy Program	• Ongoing rental subsidies for elderly or disabled Medicaid enrollees facing imminent eviction in New York City. • http://otda.ny.gov/programs/housing/
	OTDA New York State Supportive Housing Program (NYSSHP)	• Provides operating funding for supportive housing programs that serve homeless persons with disabilities such as mental illness, chemical dependency, and/or HIV/AIDS. • http://otda.ny.gov/programs/housing/
	DOH Health Home Supportive Housing Program	• Enrolled in or eligible for Health Home (2+ chronic illness or SMI or HIV/AIDS and in need of support services) • High Medicaid utilization (defined differently program to program) • Apply directly to the program • 2018 Award Winners

Supportive Housing

NYC 15/15 *(Scattered-site & Congregate)*	• Population 1: Chronically homeless single adults with a serious mental illness (SMI), a substance use disorder (SUD) (including those who are actively using or have started their recovery process within the last 12 months), or those who may have a co-occurring SMI and SUD. • Population 2: Chronically homeless families or families at serious risk of becoming chronically homeless, in which the head of the household suffers from a SMI, SUD (including those who are actively using or have started their recovery process within the last 12 months), or those who may have a co-occurring SMI and SUD. • Population 3: Young adult individuals (ages 18-25 years) who are homeless or at risk of homelessness with high service utilization of DHS, DYCD RHY, or ACS Foster Care and have risk factors • Population 4 – Young adult families with children or pregnant women 18-25 where the head of household is homeless or at risk of homelessness with high service utilization of DHS, DYCD RHY, or ACS Foster Care and have risk factors • NYC HRA • Apply through CAPS HRA 2010e

PLACEMENT AGENCY	POPULATION	CONTACT INFORMATION
HRA	A, E & F NY/NY I & II NYC 15/15 (Adult Singles) NYC 15/15 (Young Adult Singles)	Fuad Rasulov, Program Manager (212) 361-0941 Rasulovf@hra.nyc.gov
HRA	D&G NYC 15/15 (Families) NYC 15/15 (Young Adult Families)	Maria A. Rodriguez, Director of Special Projects (212) 607-6085 Rodriguezmar@hra.nyc.gov
State Office of Mental Health	B&C	Caren Abate, Director of Housing (212) 330-6367 Caren.Abate@omh.ny.gov
		Dr. Elizabeth Sieger, Young Adult Housing Liaison (212) 330-1672 Elizabeth.Sieger@omh.ny.gov
Administration for Children's Services	I	Paul Williams, Client Support Specialist (212) 676-6779 Paul.williams@acs.nyc.gov
HRA/HASA	H	John Ruscillo, Director of Housing Services (212) 620-9830 ruscilloj@hra.nyc.gov
		Alla Zarankina, Housing Unit Team Coordinator (212) 620-9763 zarankinaa@hra.nyc.gov

Supportive Housing

Empire State Supportive Housing Initiative (ESSHI)	• Serious mental illness (SMI) • Substance use disorder (SUD) • Persons living with HIV or AIDS • Victims/Survivors of domestic violence • Military service with disabilities (including veterans with other than honorable discharge) • Chronic homelessness as defined by HUD (including families, and individuals experiencing street homelessness or long-term shelter stays) • Youth/Young adults who left foster care within the prior five years and who were in foster care at or over age 16 • Homeless young adults between 18 and 25 years old • Adults, youth or young adults reentering the community from incarceration or juvenile justice placement, particularly those with disabling conditions; • Frail Elderly/Senior: Any person who is age 55 and older, who is enrolled in Medicaid, and requires assistance with one or more ADLs or instrumental ADL. • Individuals with intellectual or developmental disabilities (I/DD)

Q&A

NYC Coordinated Assessment and Placement System (CAPS)

NEW YORK-PRESBYTERIAN

APRIL 12, 2019

What is CAPS?

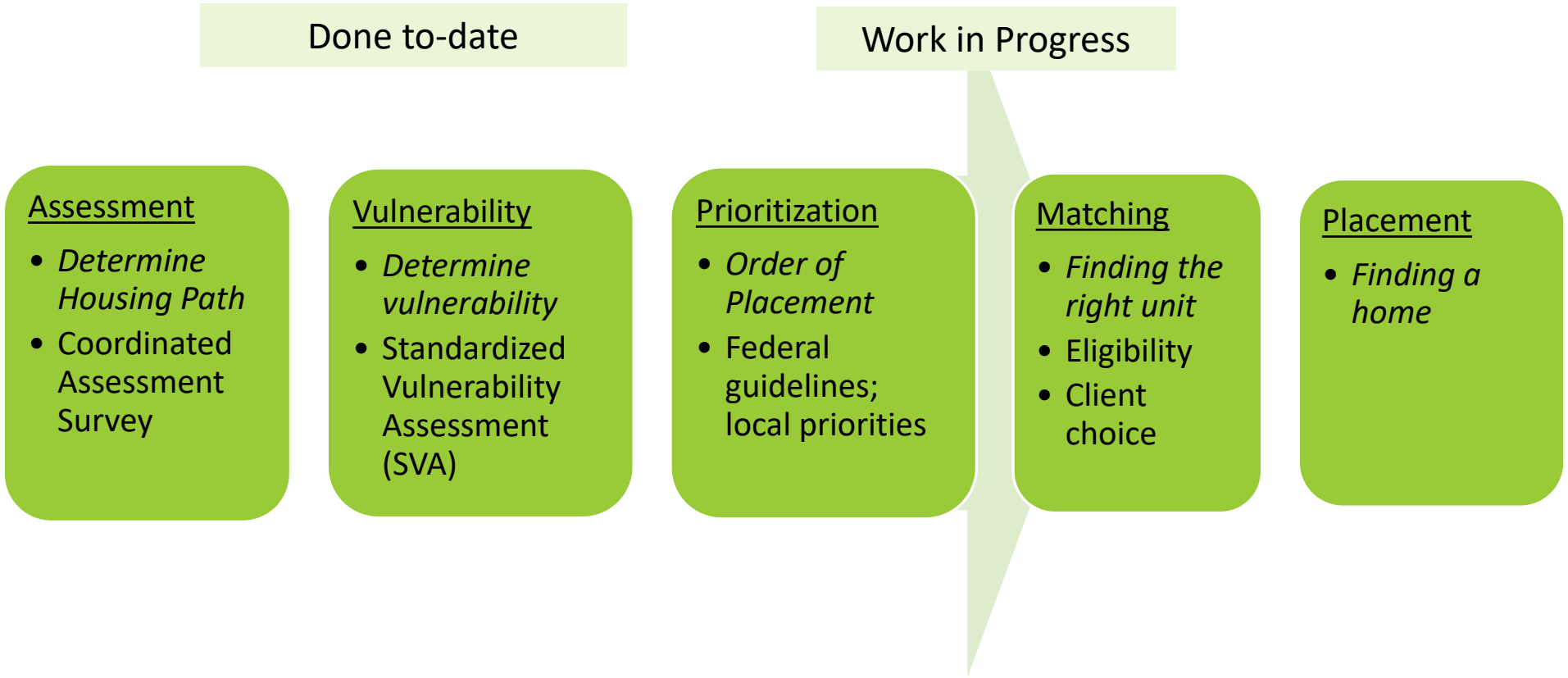
CAPS is NYC's initiative to meet the HUD requirement of Coordinated Entry

Coordinated Entry is community-wide, community-driven systems change to ensure the most vulnerable clients are placed them into permanent housing as quickly as possible

CAPS is looking at system-wide performance rather than program by program

CAPS is beginning with permanent supportive housing, but ultimately will include all types of housing

Roadmap of CAPS in NYC



Coordinated Assessment Survey

- Universal assessment tool to determine potential eligibility for housing and/or rental subsidies
- Available to all users of the PACT system
- Required before beginning a 2010e at CHS sites, HASA centers, Street Homeless Solutions outreach teams and DHS single adult assessment and program shelters
- Developing an implementation plan for family shelters, a pilot in DV shelters and including new Rapid Rehousing (RRH) programs

NYC COORDINATED ASSESSMENT & PLACEMENT SYSTEM (CAPS)

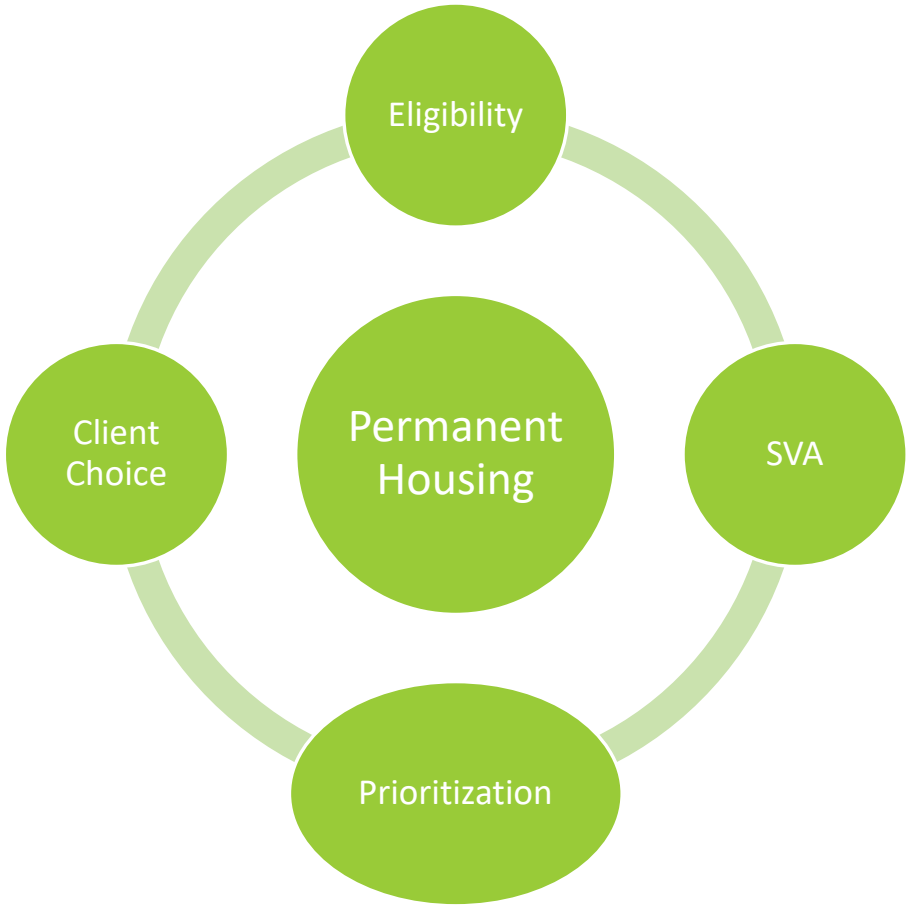
WHAT DOES THE PROCESS LOOK LIKE?

PLEASE NOTE: THIS INFOGRAPHIC ILLUSTRATES THE MOST CURRENT ITERATION OF CAPS. THROUGHOUT 2018 AND BEYOND, ADDITIONAL TYPES OF PERMANENT HOUSING OPTIONS WILL BE INCLUDED TO FULFILL THE LONG-TERM VISION OF CAPS.

Standardized Vulnerability Assessment (SVA)

Category/ Vulnerability	Medicaid Service Utilization within the past year	OR	# of System Contact and # of Functional Impairments within 2 years
High	Top 5% of Medicaid Utilization		At least 3 System Contacts and 3 Functional Impairments
Medium	Between 55% and 95% of Medicaid Utilization		At least 2 System Contacts and 2 Functional Impairments
Low	Below 55% of Medicaid Utilization		At least 1 System Contact and 1 Functional Impairment or NONE

Referral and Placement



Referral and Placement

- Currently, HRA tracks NY/NY units in the PACT system
- We are developing an enhanced referral and placement system to track other units, including CoC-funded
- Low/Medium SVA **DOES NOT MEAN** your client won't be referred
- Referrals to CoC funded units will all get HIGH and HUD Chronic

Coordinated Entry Unit

- Monitoring the HUD Chronic/Highly Vulnerable cohort
- Chairing the Case Review Workgroup
- In conjunction with the Continuous Systems Improvement (CSI) Committee, the CAPS Steering Committee and other stakeholders, review administrative data to identify gaps in our system

Early Findings

- Total surveys completed: 20,569
- Total potentially eligible for SH: 47%

Total that complete a 2010e: 64%

Approval rate for 2010e applications submitted after completing a Survey is 83%, higher than the average

2010e application rates are up 12%

Thank You!

- For more information or to schedule a training, please contact hracassupport@hra.nyc.gov

Robin Pagliuco

Director of Coordinated Entry

pagliucor@hra.nyc.gov

Supportive Housing Application Overview for Referring Agencies

Placement Assessment and Client Tracking Unit (PACT)

PACT reviews housing referral applications submitted by a wide variety of referral sources including acute and long-term psychiatric hospitals, shelters, outreach teams, correctional facilities, and community-based agencies on behalf of seriously mentally ill individuals and other target populations for placement into a continuum of supportive housing options.

Placement Assessment and Client Tracking Unit (PACT)

- The PACT unit reviewed over 25,000 applications for supportive housing in 2018.

- Of the applications received, 61% are approved for NY/NY and/or SMI housing.

Placement Assessment and Client Tracking Unit (PACT)

PACT reviews for the following types of supportive housing:

- Supportive housing for individuals with a Serious Mental Illness (SMI)
- NY/NY I/II
- NY/NY III (Populations A-I)
- Medicaid Redesign Team (MRT- for NY/NY III Pop A only)
- NYC 15 15
- DHS General Population

HRA 2010E Application

A comprehensive 2010E requires*:

- Psychiatric evaluation, by an appropriate licensed professional
- Psychosocial Assessment
- Housing documentation (unsheltered stay)
- Substance Abuse treatment letter (pop F only)

The psychiatric and psychosocial assessment must be completed *no more* than 6 months prior to submission of the application.

*for Pop E and F without mental health condition – only psychosocial is required

Serious Mental Illness (SMI)

According the NYS Office of Mental Health (OMH), in order to be considered an adult with a serious mental illness the following criteria must be met:

Designated Mental Illness Diagnosis **AND**

- SSI or SSDI Enrollment due to Mental Illness

  or

- Extended Impairment in Functioning due to Mental Illness over the past 12 months

  or

- History of reliance on Psychiatric Treatment, Rehabilitation, and Supports

NY NY I/II

- NY/NY I and II agreements signed in 1990 and 1999 for development of over 5,000 units of housing

- NY/NY I/II eligibility consists of single adults who suffer from a serious mental illness, including those with a co-occurring substance use disorder and that have been homeless 14 out of the last 60 days

NY NY III Population A

Population A consists of chronically homeless single adults who suffer from a serious mental illness, including those with a co-occurring substance use disorder

The chronic homelessness criteria is as follows:

- One year out of the last two years

  or

- Two years out of the last four years

NY NY III Population E

Population E consists of homeless single adults with an active substance use disorder

The homelessness criteria is as follows:

- Six months in the past year

Pop E- Clinical Criteria

Applications approved for population E have:

- clinical diagnosis of a substance use disorder (SUD)
- Evidence of active substance use (less than 3 months since last use)
- Demonstrated functional impairments as a result of an SUD are the primary barrier to housing
- exclusive of meeting SMI clinical criteria

NY NY III Population F

Population F consists of single adults with a substance use disorder that have completed a course of treatment and are at risk of homelessness

Homelessness criteria is as follows:

- Currently homeless

  or

- At risk of homelessness

Pop F- Clinical Criteria

Applications approved for population F have:

- Clinical diagnosis of a substance use disorder (SUD)
- Documentation of completed SUD treatment within the last year or currently engaged in SUD treatment with at least 3 months documented abstinence
- SUD treatment letter dated within the last 30 days indicating successful program participation/ completion and toxicology results for the last 90 days

NYC 15/15 Supportive Housing

Applications approved 15/15 Single Adults have:

- Clinical diagnosis of a substance use disorder (SUD) – active or early in recovery within last 12 months, OR
- Meets the criteria for SMI, OR
- Co-occurring SMI and SUD

- Must be chronically homeless according to the HUD definition

Comprehensive Application

Below are helpful tips to ensure that a comprehensive application is submitted:

- The psychosocial and psychiatric evaluation should be consistent with all information in the HRA 2010e application
- Housing history should be completed for the last four years along with supporting documentation for street homelessness from an appropriate party (street outreach team, soup kitchen, drop in, etc.)
- Clearly detail functional impairments experienced by the client as a result of their mental illness and/or substance use disorder
- Ensure that clinical documentation supports the diagnosis
- For “unable to complete” application, discuss any questions with reviewer and resubmit application asap

Application Renewals

PACT determinations for approved applications are valid for a period of one year. A new application can be submitted for review 60 days prior to an expiring approval. Updated clinical documentation is required when renewing an application. An application can be submitted using the prior clinical documentation along with an addendum, the addendum must contain the following:

- Date of the assessment
- Updated MSE
- Clinical diagnosis
- Description of the client's course of treatment and/or current functioning
- Discussion of significant clinical events that have transpired since last application (i.e. psychiatric hospitalization, suicidal/homicidal ideation and/or gestures, incarceration, etc.)

Communications with PACT

- Start with the determination letter and PACT reviewer to clarify any eligibility questions
- Seek supervision from your program around clinical documentation that is not comprehensive
- PACT supervisory review may be requested after all steps above are completed

PACT Web Enhancements

- For all approved applications, referring staff, placement entities, and supportive housing providers are able to view **Client Documents** - client identifying, employment and financial documents (i.e birth certificate, license, budget letter) in the application package section of PACT web
- Ability to upload housing placement documents post approval to facilitate placement
- Housing/Homeless page now pulls homeless data from DHS CARES, HASA Web, and prior 2010e
- New reports that detail SVA and Homelessness

Expanding Professions to complete psychiatric assessments

We expanded the list of professionals able to complete a comprehensive psychiatric evaluation for the HRA 2010e. These professions will now include:

- Licensed Psychiatrist (MD)
- Licensed Psychiatric Nurse Practitioner (NPP)
- Licensed Psychologist (PHD, PSYD)
- Licensed Clinical Social Worker (LCSW)

Standardized Vulnerability Assessment (SVA)

Category/Vulnerability	Medicaid Service Utilization within the past year	# of System Contact and # of Functional Impairments within 2 years
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How does the SVA work?

- The SVA is a data match which pulls information from three data systems **AND** from the supportive housing application (HRA 2010e)

•<u>Data systems in use</u>:

  - •PACT
  - •HRA Substance Treatment and Referral System (STARS)
  - •NYS Medicaid Data Warehouse (MDW)

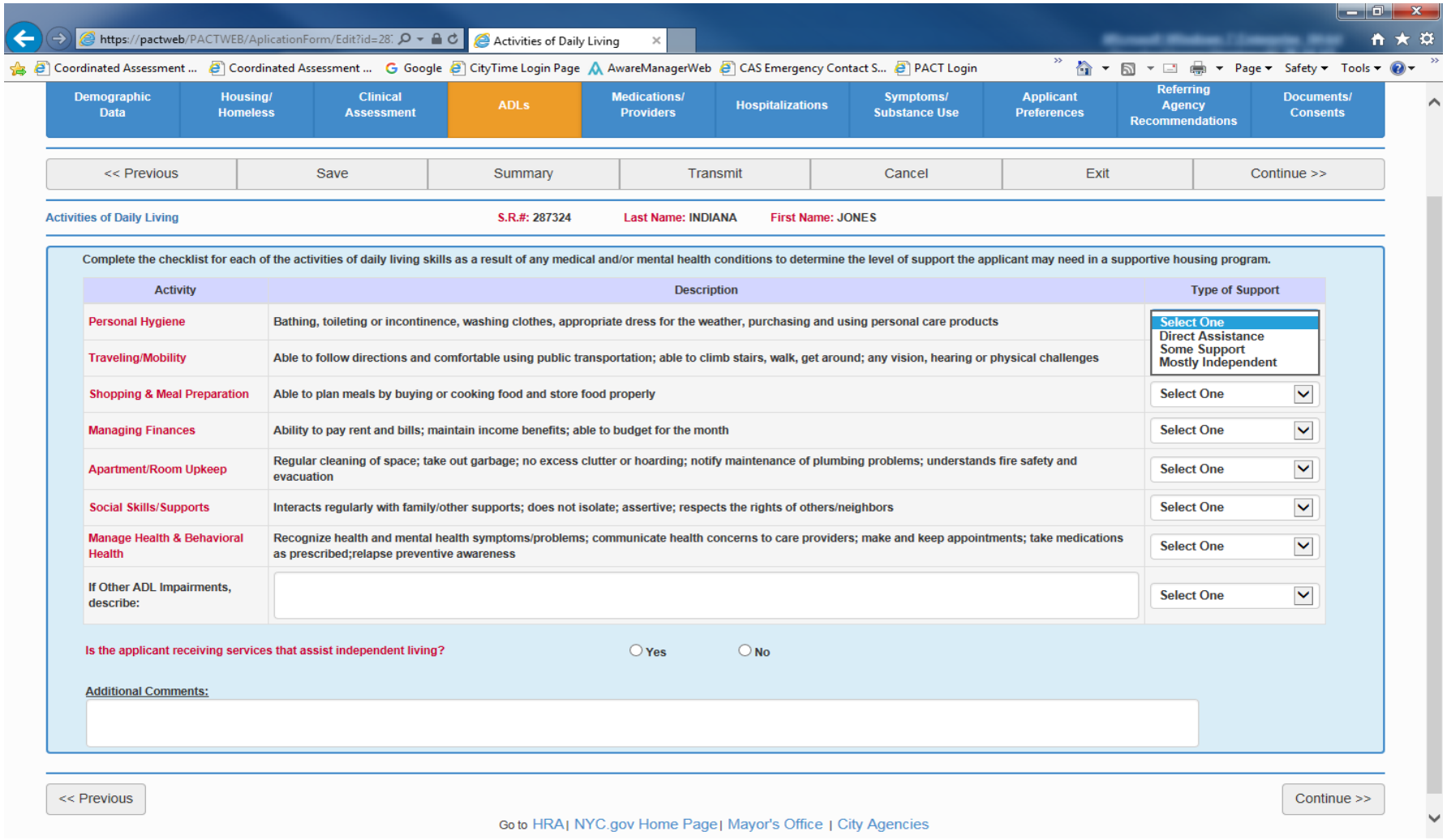
<u>Data systems in development</u>:

- DYCD shelter data
- Department of Corrections (DOC) jail stay data

2010e → SVA

- **Functional Impairments**
  - Indicated in the application in the Activities of Daily Living (ADL) section
  - It is important that the ADL section of the 2010e mirrors the clinical content in the psychiatric evaluation and psychosocial assessment
  - If the client's impairments are not described and/or indicated correctly in the 2010e, the SVA determination may not accurately reflect the client's level of vulnerability

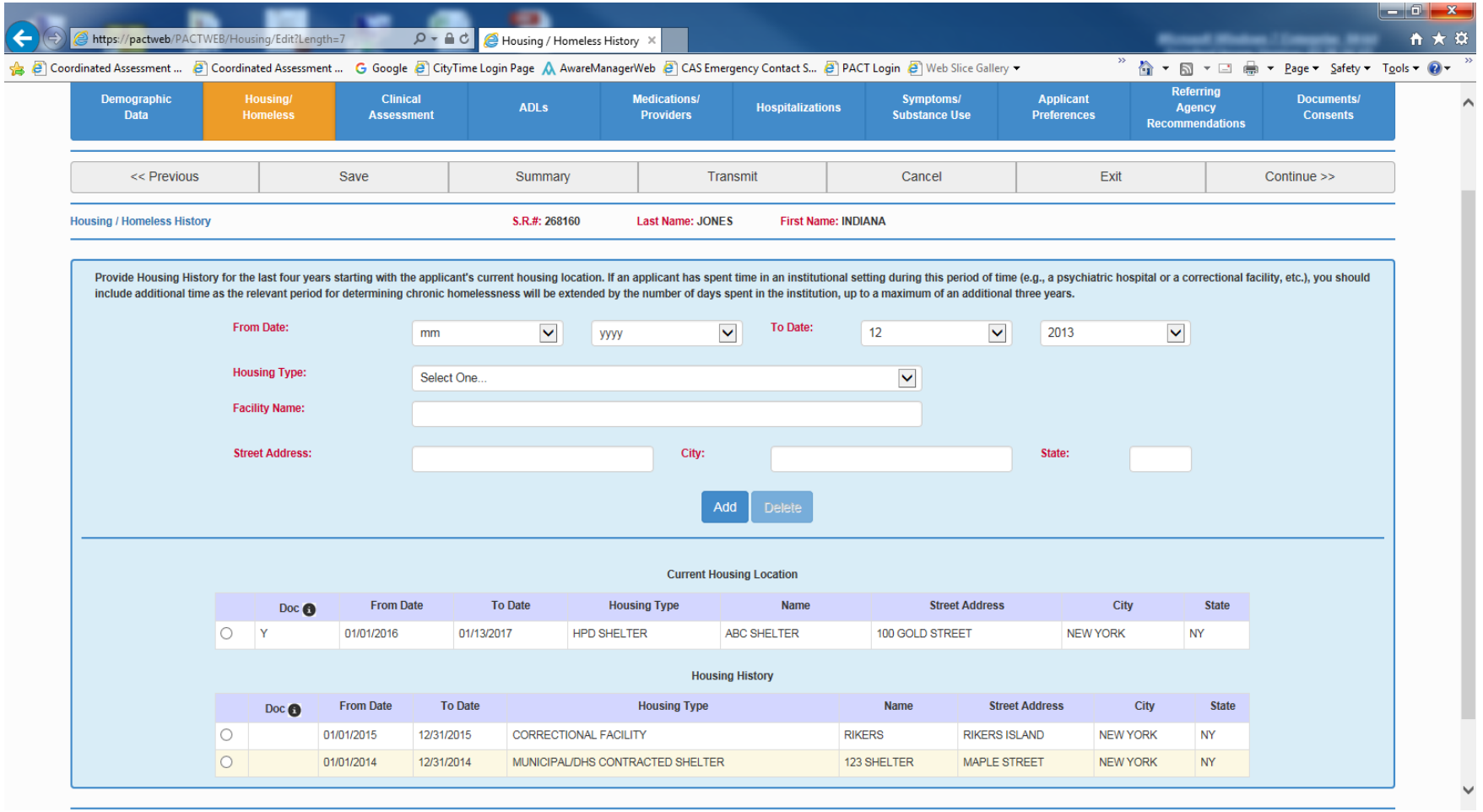
ADL Assessment in PACTWeb



2010e → SVA

- **System Contacts**
  - Indicated in the application in two ways
  - The source of the application – if it is a shelter, that is a Homeless Contact.
  - The housing and homeless history section of the application – If the application was submitted by a hospital the client would get a Hospital contact. If the housing and homeless history indicated the client was in a DHS shelter within the last two years, that would be a Homeless contact.

Housing History in PACTWeb




QUESTIONS?
COMMENTS?
CONCERNS?

Upcoming Workshops

Housing and Families	Monday, April 29th 9:30am – 11:30am	Click here to Register
Housing and Aging	Tuesday, May 14th 1:30pm – 3:30pm	Click here to Register
Housing and Mental Illness	Tuesday, May 28th 9:00am – 11:00am	Click here to Register
Housing and Youth	Wednesday, June 12th 9:00am –11:00am	Click here to Register
Housing and Active Substance Use	Date TBA	Registration details pending
Housing and Formerly Incarcerated	Date TBA	Registration details pending

Space is limited for all workshops, so please be sure to register upon announcement.

NewYork-Presbyterian
Performing Provider System

THE BRONX HEALTH & HOUSING CONSORTIUM

Thank You!
(and evaluations)

Patricia Hernandez email (housingishealth@nyp.org), Bonnie Mohan email (info@bxconsortium.org)