



OFFICE OF POLICY, PROCEDURES, AND TRAINING

James K. Whelan, Executive Deputy Commissioner

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Office of Procedures

POLICY DIRECTIVE #17-04-ELI

(This Policy Directive Replaces PD #09-31-ELI)

REVISIONS TO PROCESSING OF CASES REFERRED BY THE DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)

Date: February 2, 2017	Subtopic(s): Congregate Care
AUDIENCE	This policy directive provides instructions to Job Center staff on how to handle the cases of individuals who are applying for or are already in receipt of Cash Assistance (CA) and are referred by the Division of Voluntary and Proprietary Homes for Adults (DVPHA). This policy directive is informational for all other staff.
REVISIONS TO THE ORIGINAL PROCEDURE	<p>This Policy Directive is being revised to:</p> <ul style="list-style-type: none"> • Replace references to the Food Stamp (FS) Program with Supplemental Nutritional Assistance Program (SNAP), and Expedited FS (EFS) with Expedited SNAP (ESNAP); • Update the Congregate Care Level Shelter Types; • Update the Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid (W-200G) form; • Update the DVPHA Liaison contact phone numbers; • Update the Supportive Housing Unit address; • Update the Human Resources Administration (HRA) Office of Project Support address; • Add the Limited English Proficient and Deaf/Hard-of Hearing Implications Section.
POLICY An SSI application is a requirement for CA eligibility for residents in congregate care. An SSI application is <u>not</u> a SNAP eligibility requirement.	HRA provides a shelter allowance and a personal needs allowance to low-income aged or disabled adults who need supervised and supportive living arrangements in state-licensed homes and residences. The type of care that is offered in these homes and residences is known as congregate care. The congregate care resident must apply for Supplemental Security Income (SSI) as a condition of eligibility for CA.

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 3 at the prompt followed by 1 or
send an e-mail to *FIA Call Center Fax* or fax to: (917) 639-0298

BACKGROUND

HRA must provide an allowance for each individual receiving care in certified congregate care facility who files an application and is deemed eligible for CA. The allowance is based on the rates provided for care and maintenance under the SSI Program for SSI beneficiaries residing in the same facility, less the amount of any personal needs allowance included in the SSI rate.

Individuals usually apply for congregate care housing with the assistance of social service staff from various community sources. These include, but are not limited to, New York State (NYS) Psychiatric Centers, New York City (NYC) Health and Hospitals Corporation (HHC) facilities, private voluntary or proprietary hospitals, the Department of Homeless Services (DHS), Adult Protective Services (APS), and a wide variety of community agencies which provide social service counseling.

Revised

Note: The rate of payment for congregate care changes each year effective January 1, in accordance with the Cost of Living Adjustment (COLA) received by SSI recipients.

See [Worker's Guide to Codes](#)

Revised

New

There are three (3) levels of congregate care facilities. Each level has a different rate of payment. Please refer to the Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid (**W-200G**) for current shelter rates and personal needs allowance amounts.

Congregate Care Level 1

- Shelter Type **15** - Family-type homes for adults licensed by the Office of Children and Family Services (OCFS), Office of Mental Health (OMH) or Office for People with Developmental Disabilities (OPWDD) and operated by HRA through the Division of Voluntary and Proprietary Homes for Adults (DVPHA). These are smaller residential programs serving people with developmental disabilities, the mentally ill, and frail elderly. Facility in NYC, Nassau, Suffolk, Westchester or Rockland;
- Shelter Type **28** - Same as above in a rest of the state facility.

Note: Unlike residents of Voluntary Homes for Adults, residents of Proprietary Homes for Adults are **not** eligible to receive SNAP benefits.

Congregate Care Level 2

- Shelter Type **16** - Adult homes licensed through the New York State Department of Health (DOH) and community residences licensed through OMH. Facility in NYC, Nassau, Suffolk, Westchester or Rockland;
- Shelter Type **29** - Same as above in a rest of the state;

Revised

New

- New • Shelter Type **31** - Residential Alcohol and Substance Abuse Treatment Programs. Facility in NYC, Nassau, Suffolk, Westchester or Rockland;
- New • Shelter Type **32** - Same as above in a rest of the state facility;
- Shelter Type **43** - Community Residences licensed through OMH/OPWDD. These are principally small group homes and supported apartments. Cases that were previously coded as Shelter Type **16**, but live in an apartment-like setting and are now coded as Shelter Type **43**. The case can be larger than a family size of 1.

Congregate Care Level 3

Shelter Type **42** - DOH Adult Homes and Enriched Housing facilities. The case **must be** a family size of 1.

Note: Residential Drug and Alcohol Treatment Facilities are not governed by the DVPHA referral process and are not covered by this policy directive. See [PD #12-14-EMP](#) and [PD #00-33R](#).

REQUIRED ACTION

DVPHA Process

Revised Social service staff from community agencies providing counseling can request approval for Supportive Housing either in writing, via the **HR-1990M** form for medical reasons, or electronically for mental health cases, via the **HRA 2010(e)** form to the Supportive Housing Unit at 4 World Trade Center, 150 Greenwich Street, 30th Floor, New York, NY 10007.

New **Note:** The **HRA 2010(e)** form is available on-line only to clinical staff with assigned passwords.

The completed **HR-1990m** and **HRA 2010(e)** forms are forwarded to DVPHA, which oversees the placement of eligible individuals and/or couples into the appropriate type of adult home. DVPHA also makes referrals for CA, when appropriate. DVPHA is part of Medical Insurance and Community Services Administration (MICSA).

DVPHA is responsible for maintaining a roster of facilities where eligible individuals for CA will be located. If the individual is applying for congregate care in a Level 2 or Level 3 facility, the facility must be registered with DVPHA.

Once the Notice(s) of Admission/Request(s) for CA is/are received at DVPHA, the notices of those individuals who will be referred to the Family Independence Administration (FIA) are attached to a DVPHA transmittal sheet (**HR-11**) and forwarded via fax to the appropriate Job Center. The **HR-11** form notifies the Job Center that the applicant has been admitted for placement to a particular congregate care facility and provides the “pick up” date for payment. The “pick up” date is the start date for payment and is not necessarily the same as the individual’s date of admission into the congregate care facility.

DVPHA may request that the Job Center pay prorated “one-shot” expenses for an applicant/participant who moved into a facility before the SSI payment was received.

DVPHA may request that the Job Center activate a case with income from SSI and/or Retirement Survivors Disability Insurance (RSDI). In some cases, reduction in the income due to garnishment or repayment of a prior overpayment. DVPHA is responsible for verifying that the applicant/participant has requested a waiver from the Social Security Administration (SSA) to reduce the deduction for the overpayment.

Active CA Cases

When a Notice of Admission/Request for CA is received by DVPHA for an individual that is active on a CA case, DVPHA will forward the notice and the **HR-11** form via fax to the Administrative Assistant (AA) to the Director of the Job Center that has the active case.

Active cases

Upon receipt of the packet, the AA to the Job Center Director “clocks in” the **HR-11** form for control purposes and forwards it to the appropriate Associate Job Opportunity Specialist (AJOS) I. The AJOS I will assign the case to the JOS/Worker, who is responsible for taking the following case actions in Paperless Office System (POS):

Revised

- Single-person Cases

Revised

- Change the payee/case name to “(Facility Name) for (Case Name)”, e.g., “Golden Horizon for John Smith”;
- Change the mailing address to (Case Name c/o Facility Name) and the facility’s address;
- Indicate the appropriate congregate care facility type;
- Indicate if a participant is disabled;
- Indicate if a participant is in receipt of other income;
- Prepare a new budget;

- A semimonthly personal needs allowance and an appropriate shelter rate will be automatically generated in accordance with the schedule on the **W-200G** form;
 - Issue a shelter allowance from the date of placement in the home as indicated on the transmittal (**HR-11**) from DVPHA;
 - Rent payments to the facility listed on the **HR-11** form will be direct vendor payment;
 - All payments for the personal needs allowance are issued as electronic transfers to the facility. Facility is responsible for disbursement of funds to the residents;
 - Enter case comments in POS indicating all actions taken on the case, and send the case to the AJOS I for approval.
- Multiple-person Cases

Revised

- Review the CA case. If all members on the case are moving into congregate care, follow the same instructions given for a Single-person case (see above);
- If some household members are not moving into the congregate care facility, close the line(s) on the active case of the individual(s) who is/are moving into the facility. Establish a new case for these individual(s) only;
- If Shelter Type is **42**, each participant requires a separate case, even if living together;
- Follow the same instructions given for a Single-person case (see above).

Upon completion of these actions, the Center must transfer the case to the Center that covers the congregate care facility's address. In Brooklyn, the Institute for Community Living (ICL) has an agreement that all of its cases will go to Bushwick Job Center #66 located at 30 Thornton Street, 3 Floor, Brooklyn, NY, 11206 .

Non-active Cases

Non-active cases

If the individual is not active on a CA case, the packet containing the **HR-11** form is sent from DVPHA to the Center covering the Zip Code of the congregate care facility. In Brooklyn, the ICL has an agreement that all of its cases will go to Bushwick Job Center #66 located at 30 Thornton Street, 3 Floor, Brooklyn, NY, 11206 .

Note: All DVPHA cases should be treated as homebound. Verification of actual homebound status must be obtained

For new applicants, the AA to the Center Director forwards the package from DVPHA to the AJOS II. The AJOS II assigns the case to the AJOS I next in line to receive an application case, who then assigns the case to a JOS/Worker. A JOS/Worker will send an email to the Job Center #90 at Ctr90HVNRquests@hra.nyc.gov to request a homebound visit to the congregate care facility.

New

The Home Visit Needed (HVN) Unit JOS/Caseworker will conduct a homebound visit, obtain all necessary documentation, complete the application interview, and eligibility determination in POS as per [PD #16-26-OPE](#).

These households must be screened for ESNAP service. If the applicant is found eligible for ESNAP service and the facility has been designated as the household's authorized representative, the facility will receive SNAP on the applicant's behalf.

Eligibility must be determined within 30 days from the time the HRA forms were clocked in. CA benefits must be available by the 45th day where appropriate.

These cases must be processed in a timely manner and CA benefits must be made available within 30 or 45 days of receipt of the **HR-11** form, based on family composition and category of assistance. SNAP benefits must be made available within 30 days, if eligible. However, shelter payments for these facilities are considered an emergency and must be paid during the application period. A delay in the processing of these cases may place this particularly vulnerable population in jeopardy of eviction.

Note: It is imperative that both active and non-active cases be processed in a timely manner

The JOS/Worker annotates the **HR-11** form indicating the following information:

- Date the case was accepted;
- Amount of grant(s) issued; and
- Period(s) covered.

The AJOS I will:

- Control the case and ensure that eligibility is determined and CA benefits are available 30 or 45 days from the application file date as appropriate.
- Ensure that SNAP benefits are issued within 30 days from the application file date.
- Annotate the **HR-11** form and return it to the AJOS II as soon as he/she has signed off on the case.

Upon receipt of the annotated **HR-11** form, the AJOS II copies the sheet and forwards it to:

Revised

HRA Office of Project Support
4 World Trade Center
150 Greenwich Street, 36th Floor
New York, NY 10007
Attention: DVPHA Liaison

The **HR-11** form should be hand-delivered and signed once it arrives at the HRA Office of Project Support.

In Model Centers provide the congregate care resident with a CSIC General ticket

Note: All staff must be aware that some residents of congregate care facilities may walk into a Job Center with a representative from the facility to request services. If the individual’s case is active, alert the AJOS I of the group that was assigned the case for follow-up action. If the case is not known to the Center, alert the AA to the Director. He/she will determine whether the **HR-11** form has already been received, or whether this is a new case that needs the **HR-11** form. Contact the DVPHA Liaison for assistance at (929) 221-6692, (929) 221-6688, or (929) 221-7383.

Revised

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications

POS implications are included in this policy directive.

SNAP Implications

SNAP applications for all individuals in congregate care who are also applying for CA are processed by Job Center staff.

See NPA FS Budgeting Manual, Appendix E.

Residents of congregate care facilities are eligible for SNAP if they are in receipt of RSDI or SSI, or have an “X” in the Aged or Disabled (A/D) indicator field on the **NSBL06** screen of the WMS budget. Residents who do not receive either RSDI or SSI but who are receiving “treatment and care” within the facility are considered to be disabled. This includes “private pay” residents and residents receiving cash assistance.

Applicants/participants residing in Congregate Care Level 1, Congregate Care Level 3, and most Congregate Care Level 2 facilities may apply for SNAP either on their own behalf, through an authorized representative employed and designated by the facility, or through an authorized representative of their choice.

Staff at these facilities must determine whether a resident may apply on his/her own behalf, based on the resident’s physical and mental ability to handle his/her own affairs.

Applicants/participants residing in Congregate Care Level 2 Drug/Alcohol Residential Treatment Facilities **must** apply through an authorized representative employed and designated by the facility.

SNAP determinations for residents of Drug/Alcohol Residential Treatment Facilities are made by staff at Job Center #52, Residential Treatment Service Center (RTSC).

The following residents are **not** eligible for SNAP benefits:

- Residents of medical facilities;
- Residents of medical institutions; and
- Residents of Proprietary Homes for Adults.

New applicants must be screened to determine whether they are eligible for ESNAP processing. If the applicant is found eligible for ESNAP, the SNAP benefit must be issued within five days of the SNAP application file date. If the facility has been designated as the household's authorized representative, the facility will receive the SNAP on the applicant's behalf.

Medicaid Implications

There are no Medicaid implications.

LIMITED ENGLISH PROFICIENT AND DEAF/HARD-OF-HEARING IMPLICATIONS

For Limited English Proficient (LEP) and Deaf/Hard-of-Hearing applicants/participants, make sure to obtain appropriate interpreter services in accordance with [PD #16-14-OPE](#) and [PD #16-16-OPE](#).

FAIR HEARING IMPLICATIONS

Applicants/participants who receive an adverse action on their congregate care CA application as a result of this process are entitled to request a Fair Hearing.

Avoidance/Resolution

Remember to give the applicant/participant or representative an opportunity for a conference/resolution on the issue.

Conferences

An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS I/Supervisor I at any time. If an applicant/participant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. In Model Offices, the Receptionist at Main Reception will issue an FH&C ticket to the applicant/participant to route him/her to the FH&C Unit and does not need to verbally alert the FH&C Unit staff.

The FH&C AJOS I/Supervisor I will listen to and evaluate any material presented by the applicant/participant, review the case file and discuss the issue(s) with the JOS/Worker responsible for the case and/or the AJOS I/Supervisor I. The AJOS I/Supervisor I will explain the reason for the Agency's action(s) to the applicant/participant.

If the determination is that the applicant/participant has presented good cause for the infraction or that the outstanding Notice of Intent needs to be withdrawn for other reasons, the FH&C AJOS I /Supervisor I will settle in conference (SIC), enter detailed case notes in NYCWAY and forward all verifying documentation submitted by the applicant/participant to the appropriate JOS/Worker for corrective action to be taken.

In addition, if the adverse case action still shows on the "Pending" (08) screen in WMS, the AJOS I/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form (LDSS-3722), change the 02 to an 01 if the case has been granted aid continuing (ATC), or prepare and submit a PA Recoupment Data Entry Form (LDSS-3573) to delete a recoupment. The AJOS I/Supervisor I must complete a Conference Report Form (M-186a).

If the determination is that the applicant/participant has not shown good cause for the infraction or that the Agency's action(s) should stand, the AJOS I/Supervisor I will explain to the applicant/participant why he/she cannot SIC. The AJOS I/Supervisor I must complete Form M-186a.

Should the applicant/participant elect to continue his/her appeal by requesting a Fair Hearing or proceeding to a Fair Hearing already requested, the FH&C AJOS I/Supervisor I is responsible for ensuring that further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

Evidence Packets

All Evidence Packets must include the Notice of Action Taken on Your Application and all documentation relevant to the issue to support the Agency's action.


REFERENCES

Public Assistance Budgeting Manual, Appendix E
 NPA/SNAP Budgeting Manual, Appendix E
 Worker’s Guide to Codes
 OTDA 08-INF-04, Attachments 1 and 3
 GIS 08 TA/DC022
 7 CFR 273.2(n)(1)(ii)
 7 CFR 273.11(f)
 18 NYCRR 387.14(5)(iii)(f)

RELATED ITEMS

[PD #16-26-OPE](#)
[PD #12-14-EMP](#)
[PD #00-33R](#)

ATTACHMENTS

 Please use Print on Demand to obtain copies of forms.

- EXP 9705** Notification of Admission to a Congregate Care Home Referral for Interim Safety Net Grant – Single Issue
- HR-11 series:**
- HR-11 Level III** Notification of Placement in an Approved Congregate Care Level III Adult Care Facility
- HR-11 Level II** Notification of Placement in an Approved Congregate Care Level II Adult Care Facility
- HR-11 Level III** D.O.P.I.S. Notification of Placement in an Approved Congregate Care Level III Adult Care Facility
- HR-11 Level II** D.O.P.I.S. Notification of Placement in an Approved Congregate Care Level II Community Residence
- HR-11 Level II** Notification of Admission to a Congregate Care Level II Facility Re-budgeting of Safety Net Assistance Grant and Active Transfer
- HR-11 Level III** Notification of Admission to a Congregate Care Level III Facility Re-budgeting of Safety Net Assistance Grant and Active Transfer
- HR-11 Level I** Notification of Placement in an Approved Level I, Family Type Home for Adults
- HR-11 Level I** Notification of Admission to a Level I, Family Type Home for Adults Re-budgeting of Safety Net Assistance Grant and Active Transfer
- HR-11B** Application for Safety Net Assistance/SSI Recoupment For DVPHA Home Resident
- HR-11T** Notification of Approved Transfer from one Family Type Home to another Family Type Home for Adults
- HRA-1990M** NYC HRA Housing Placement Application

W-200G

Shelter Rates and Personal Needs Allowance for
Congregate Care Facilities Desk Aid (Rev. 2/2/17)

HRA/ADULT PROTECTIVE SERVICES
 DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
 DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
 400 8TH Avenue, 8Th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

Notification of Admission to a Congregate Care Home Referral for Interim Safety Net Grant – Single Issue

Page 1 of Pages

To: FIA Support Center:		FAX		Date:	
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Attn: _____

From:	Telephone Number:
Client Name	DOB
	SSN

In accord with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the Supplemental Security Income (SSI) program will begin payment for eligible persons as of the first day of the month after admission to a Congregate Care home or residence. The home or residence of the above client reports not being paid for the initial period of housing. Therefore we are requesting evaluation for application for Safety Net Assistance for a SINGLE ISSUE payment.

The period excluded by SSI is: _____ **to** _____

The admission date is: _____ **Pick-up date is:** _____

The amount due is \$ _____

Check type of facility:

- _____ Level I Family Type Home for Adults (shelter code 15)
- _____ Level II Community Residence (shelter code 16)
- _____ Level III Adult Home or ALP (shelter code 42)

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

Notification of Placement in an Approved Congregate Care Level III Adult Care Facility

Page 1 of Pages

To: FIA Support Center:		Fax:		Date:	
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Attn:

From:	Telephone Number:	
Client Name	DOB	SSN

We are forwarding the attached approved Housing Placement Referral Application for Safety Net Assistance. The above person has been admitted to a licensed Congregate Care Level III Adult Home. Please budget according to the Congregate Care Level III rate.

Please schedule a homebound application appointment as soon as possible. A temporary Medicaid card may be needed for medication for this disabled resident

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 42 as type of living arrangement.
2. Obtain Form DSS-2474, verifying application for SSI benefits.
3. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

Notification of Placement in an Approved Congregate Care Level II Adult Care Facility

Page 1 of Pages

To: FIA Support Center:		Fax:		Date:	
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Attn: _____

From: _____ **Telephone Number:** _____

Client Name	DOB	SSN
_____	_____	_____

We are forwarding the attached approved Housing Placement Referral Application for Safety Net Assistance. The above person has been admitted to a licensed Congregate Care Level II Community Residence. Please budget according to the Congregate Care Level II rate.

Please schedule a homebound application appointment as soon as possible. A temporary Medicaid card may be needed for medication for this disabled resident

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 16 as type of living arrangement.
2. Obtain Form DSS-2474, verifying application for SSI benefits.
3. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

D.O.P.I.S

**Notification of Placement in an Approved
Congregate Care Level III Adult Care Facility**

Page 1 of Pages

To: FIA Support Center:		Fax:		Date:	
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Attn:

From:	Telephone Number:
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Client Name	DOB	SSN

We are forwarding the attached approved Housing Placement Referral Application for Safety Net Assistance. The above person has been discharged from a NYSOMH facility, and admitted to a licensed Congregate Care Level III Adult Home. This person is 100% Medicaid reimbursable as a MA State charge case. Please budget according to the Congregate Care Level III rate.

Please schedule a homebound application appointment as soon as possible. A temporary Medicaid card may be needed for medication for this disabled resident.

In WMS/TAD under St/Fed enter Code 05 in box 307 and DOPIS/621 eligible date: _____ in box 325.

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 42 as type of living arrangement.
2. Obtain Form DSS-2474, verifying application for SSI benefits.
3. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

D.O.P.I.S

**Notification of Placement in an Approved
Congregate Care Level II Community Residence**

Page 1 of Pages

To: FIA Support Center:		Fax:		Date:	
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Attn:

From:	Telephone Number:
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Client Name	DOB	SSN

We are forwarding the attached approved Housing Placement Referral Application for Safety Net Assistance. The above person has been discharged from a NYSOMH facility, and admitted to a licensed Congregate Care Level II Community Residence. This person is 100% Medicaid reimbursable as a MA State charge case. Please budget according to the Congregate Care Level II rate.

Please schedule a homebound application appointment as soon as possible. A temporary Medicaid card may be needed for medication for this disabled resident.

In WMS/TAD under St/Fed enter Code 05 in box 307 and DOPIS/621 eligible date: _____ in box 325.

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 16 as type of living arrangement.
2. Obtain Form DSS-2474, verifying application for SSI benefits.
3. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

Notification of Admission to a Congregate Care Level II Facility
Re-budgeting of Safety Net Assistance Grant and Active Transfer

Page 1 of Pages

To: FIA Support Center:	Fax:	Date:
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Attn: _____

From:	Telephone Number:
Client Name	DOB
	SSN

We are forwarding the attached approved Housing Placement Referral Application for the above person who has been admitted to a licensed Congregate Care Level II Community Residence facility. Please budget according to the Congregate Care Level II rate.

Please transfer active case, after re-budgeting to Job Center #: _____

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 16 as type of living arrangement.
2. Obtain Form DSS-2474, verifying application for SSI benefits.
3. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

Notification of Admission to a Congregate Care Level III Facility
Re-budgeting of Safety Net Assistance Grant and Active Transfer

Page 1 of Pages

To: FIA Support Center:	Fax:	Date:
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Attn: _____

From:	Telephone Number:
Client Name	DOB
	SSN

We are forwarding the attached approved Housing Placement Referral Application for the above person who has been admitted to a licensed Congregate Care Level III Adult Home facility. Please budget according to the Congregate Care Level III rate.

Please transfer active case, after re-budgeting to Job Center #: _____

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 42 as type of living arrangement.
2. Obtain Form DSS-2474, verifying application for SSI benefits.
3. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

**Notification of Placement in an Approved
Level I, Family Type Home for Adults**

Page 1 of Pages

To: FIA Support Center:		Fax:		Date:	
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Attn: _____

From: _____ **Telephone Number:** _____

Client Name	DOB	SSN
_____	_____	_____

We are forwarding the attached approved Housing Placement Referral Application for Safety Net Assistance. The above person has been admitted to a licensed Level I, Family Type Home for Adults. Please budget according to the Congregate Care Level I rate.

Please schedule a homebound application appointment as soon as possible. A temporary Medicaid card may be needed for medication for this disabled resident

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 15 as type of living arrangement.
2. Obtain Form DSS-2474, verifying application for SSI benefits.
3. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

Notification of Admission to a Level I, Family Type Home for Adults
Re-budgeting of Safety Net Assistance Grant and Active Transfer

Page 1 of Pages

To: FIA Support Center:	Fax:	Date:
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Attn: _____

From:	Telephone Number:
Client Name	DOB
	SSN

We are forwarding the attached approved Housing Placement Referral Application for the above person who has been admitted to a licensed Congregate Care Level I Family Type Home for Adults. Please budget according to the Congregate Care Level I rate.

Please transfer active case, after re-budgeting to Job Center #: _____

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 15 as type of living arrangement.
2. Obtain Form DSS-2474, verifying application for SSI benefits.
3. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

**Application for Safety Net Assistance/SSI Recoupment
For DVPHA Home Resident**

Page 1 of Pages

To: FIA Support Center:		Fax:		Date:	
--------------------------------	--	-------------	--	--------------	--

Attn: _____

From: _____ **Telephone Number:** _____

Client Name	DOB	SSN
_____	_____	_____

According to NYS Dept. of Social Services regulations (352.16) (d), when SSI recipients are applying for Safety Net benefits, and being recouped by the Social Security Administration (SSA), that portion of the money being recouped must not be considered as available income when determining eligibility for SNA in accordance with all SNA program standards. The SN budget must be based on shelter needs added to the basic allowance, plus any applicable special needs. An applicant must not be denied SNA solely on the basis of receiving SSI money and being recouped by the SSA for an SSI overpayment.

Therefore HRA must do a budget based on DVPHA rates (Congregate Care Level I, II or III rates) and if found eligible, applicant should be granted the difference of SSI monies not covered for needs; during such time as applicant remains a resident of the home and continues to be eligible for Public Assistance; and until applicant's circumstances change, if any, with the SSI money

Please schedule a homebound application appointment as soon as possible for this disable resident.

The client is a resident of (Check type of facility):

- _____ Level I Family Home for Adults (shelter code 15)
- _____ Level II Community Residence (shelter code 16)
- _____ Level III Adult Home or ALP (shelter code 42)

The total grants must not exceed the total recoupment amount.

The total SSA/SSI recoupment amount is _____

_____ **Single Issue** grant for _____ Is needed for the period from _____ to _____

_____ **Recurring** semi-monthly grant is _____ A recurring grant is needed from the pick-up-date.

Admission Date: _____ **Pick-up Date:** _____

Client Address: _____

Name of Home/Residence: _____

Payment Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

HRA/ADULT PROTECTIVE SERVICES
DIVISION OF POST INSTITUTIONAL SERVICES (DOPIS)
DIVISION OF VOLUNTARY AND PROPRIETARY HOMES FOR ADULTS (DVPHA)
400 8th Avenue, 8th FLOOR, NEW YORK, NY 10001-TEL (212) 971-0046, FAX (212) 971-0144

Notification of Approved Transfer from one Family Type Home to another Family Type Home for Adults

Page 1 of Pages

To: FIA Support Center:		Fax:		Date:	
--------------------------------	--	-------------	--	--------------	--

Attn: _____

From:	Telephone Number:
Client Name	PA#
	SSN

We are forwarding an approved transfer for the above person who has been transferred from one licensed Family Home to another licensed Family Home for Adults. Both are Level I homes and the Congregate Care Level I rate should remain in effect.

This case should be transferred to Job Center Number: _____

A temporary Medicaid Card may be needed for medication for this disabled resident.

Refer to FIA Policy Directive # 17-04-ELI:

1. Use shelter code 15 as type of living arrangement.
2. For Food Stamp eligibility, please see Budgeting Manual, Appendix E.

The effective transfer date is: _____

Name of Home/Residence: _____

Address: _____ **Zip Code:** _____

Telephone Number: _____ **Contact Person:** _____

Reply from Income Support Center:

(Acceptance date, issue date, amount granted, SNA case number, other information as needed)

NYC HRA Housing Placement Application

INSTRUCTIONS

- ▶ Form HRA-1990M is used to apply for housing placement for persons who require supportive services primarily for reasons of MEDICAL / FUNCTIONAL disabilities.
- ▶ The disclosure of HIV related information requires a Special Consent to Release Information form signed by the applicant. This is attached as page 5 of this Application.
- ▶ ALL APPLICATIONS must be submitted with a complete PSYCHOSOCIAL SUMMARY which explains the type of supportive services the applicant needs.
- ▶ DVPHA approval MUST be obtained prior to placement in all FAMILY homes.
- ▶ Approval is effective for a period of 90 days, then a request for renewal must be submitted.

Check boxes for housing requested:

- Family-type Home for Adults**
- Foster Family Care Home ***
** Submit Application with M-27r Nurse's Assessment*
- Adult Home**
- Adult Home Assisted Living**

Is a specific Home being requested? No
 Yes (specify) _____

Send to: DVPHA Applications Intake
400 8th Avenue, 8th floor
New York, NY 10001
FAX: (212) 971-0144

SECTION A: IDENTIFYING INFORMATION

1. Name: Last _____
 First _____

2. AKA _____

3. Birth date: ____/____/____ (Age: _____)

4. Social Security Number: ____/____/____

5. Male Female

6. Shelter H.A. #: _____

7. Ethnicity: _____

8. Religion: _____

9. Marital Status: _____

10. Applicant's location: _____
If applicant is hospitalized give address prior to admission.

Admission date to hospital: _____
 Give last known address: _____

11. Citizenship: USA Other

If other, specify: _____

Alien Registration #: _____

12. Is applicant a veteran?
 Yes: type of discharge: _____
 No

13. Indicate any programs applicant attends regularly:

Program Name	Contact Person	Phone Number
1.	/	/
2.	/	/
3.	/	/

14. Check all sources of income applicant receives:

	AMOUNT \$	I.D. #
<input type="checkbox"/> Soc Sec		
<input type="checkbox"/> SSI		
<input type="checkbox"/> SSD		
<input type="checkbox"/> P.A.		
<input type="checkbox"/> Medicare		
<input type="checkbox"/> Medicaid		
<input type="checkbox"/> Veterans		
<input type="checkbox"/> Pension		
<input type="checkbox"/> Food Stamps		
<input type="checkbox"/> Other		

NAME OF APPLICANT:	SS #:
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SECTION A: Continued

15. Describe any special payee arrangements:

17. Family/Friend/Emergency Contact(s):
(Include name, address, phone)

SECTION C: HOUSING ASSESSMENT

1. Does applicant speak English? Yes No

Primary language: _____

2. First and second borough preferences:

(1) _____

(2) _____

3. Does applicant have difficulty in the following?

	Yes	No
Money Management	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition	<input type="checkbox"/>	<input type="checkbox"/>
Use of Leisure Time	<input type="checkbox"/>	<input type="checkbox"/>
Program Participation	<input type="checkbox"/>	<input type="checkbox"/>
Socialization	<input type="checkbox"/>	<input type="checkbox"/>
Travel	<input type="checkbox"/>	<input type="checkbox"/>
Securing/Maintaining Income/Benefits	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>
Use of Health Services	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>

4. Check any alternative housing/placement options being considered in addition to those on page 1:

Transitional Setting

SNF/HRF

PWA Housing

Lodging House

Unserviced SRO

Independent Apartment

5. Are any services needed once applicant is housed?

	Yes	No
Senior Center	<input type="checkbox"/>	<input type="checkbox"/>
Psych. Day Program	<input type="checkbox"/>	<input type="checkbox"/>
Drop-in program	<input type="checkbox"/>	<input type="checkbox"/>
Psych. clinic/psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug treatment services	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholics/Narcotics Anonymous	<input type="checkbox"/>	<input type="checkbox"/>
Vocational Program	<input type="checkbox"/>	<input type="checkbox"/>
On-site Case Management Services	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial Club	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B: RESIDENTIAL HISTORY

1. Has applicant ever been homeless? Yes No
If YES, complete the following:
(Include dates of present episode of homelessness; include name of shelter, drop-in center, street, etc. under Location.)

Dates	Location

2. Where did applicant reside prior to this request for placement? (Indicate facility if appropriate.)

Own apartment/house

With family

With friend(s)

Single room occupancy residence

Community Residence

Adult Home/Residence

Inpatient psychiatric facility

Jail

Unknown

Other _____

Facility: _____

3. Length of occupancy, in months: _____

4. Reason for leaving: _____

NAME OF APPLICANT:

SS #:

SECTION D: MENTAL HEALTH INFORMATION

Does the patient/applicant have any history of or current need for psychiatric care?

Yes No If YES, continue to D.1.

If NO, skip Section D and continue with Section E.

1. Current diagnosis:		DSM IIIR Code	
Axis I:			
Axis II:			
2. Current Psychotropic Medications:			
Name	Dosage	Schedule	
3. To the degree known list all psychiatric hospitalizations and emergency room use: (Include current hospitalization)			
Hospital/ER	Admission Date	Discharge Date	Source of Information

3. Does patient/applicant have a history of or is currently exhibiting any of the following?

(Fill in all items; check H for HISTORY, C for CURRENT, both H and C if appropriate, N for NEITHER, or U, for UNKNOWN.)

	<u>C</u>	<u>H</u>	<u>N</u>
Suicidal ideas/attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal ideas/attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe thought disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violence/assaultiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arson/firesetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Criminal activity/arrests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Does applicant have a history of substance abuse?

Yes; substances(s): _____
 No

5. Reported degree of problem:

Occasional use Not applicable
 Chronic addiction Unknown
 Habitual use

6. Does applicant have a history of substance abuse treatment? Yes No

Name of Treatment Program	Dates

7. Length of time applicant has been substance free:
(In months)

Alcohol: _____ Not applicable
Drugs: _____ Not applicable

SECTION E: MEDICAL INFORMATION

1. In what manner does applicant take medication?

Staff dispensed Independent
 Staff supervised Refuses
 Staff reminders Not applicable

2. Is applicant compliant with medication regimen?

Yes No

NAME OF APPLICANT:	SS #:
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SECTION E: MEDICAL INFORMATION Continued

The disclosure of HIV related information, if relevant, must be accompanied by a Special Consent to Release form signed by the applicant. This form is attached as page 5 of this Application.

8. Medical Diagnosis (Axis III):

9. Current Medications:

Name	Dosage	Schedule

10. Does applicant have a medical condition that requires special services such as special medical equipment, medical supplies, ongoing physician support, and/or a therapeutic diet?

No Yes, Describe: _____

11. Physical Functioning Level:

(Please answer each of the following)

	Yes	No
Bedridden	<input type="checkbox"/>	<input type="checkbox"/>
Amputee	<input type="checkbox"/>	<input type="checkbox"/>
Blind	<input type="checkbox"/>	<input type="checkbox"/>
Deaf	<input type="checkbox"/>	<input type="checkbox"/>
Incontinent	<input type="checkbox"/>	<input type="checkbox"/>
Needs help with toileting	<input type="checkbox"/>	<input type="checkbox"/>
Fully ambulatory	<input type="checkbox"/>	<input type="checkbox"/>
Climbs 1 flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair required	<input type="checkbox"/>	<input type="checkbox"/>
Can bathe self	<input type="checkbox"/>	<input type="checkbox"/>
Can dress self	<input type="checkbox"/>	<input type="checkbox"/>
Can feed self	<input type="checkbox"/>	<input type="checkbox"/>
Can self-inject medication	<input type="checkbox"/>	<input type="checkbox"/>

12. Medical Tests:

(All medical tests should have been completed within the last 90 days.)

A. Chest X-ray: Date: _____

Interpretation: _____

B. Is applicant free from TB and other communicable diseases?

No Yes, Explain: _____

C. Lab Data: WBC: _____

Hg: _____

EKG: _____

Urinalysis: _____

Physician Signature: _____

Printed Name: _____

Date: _____

REFERRING AGENCY:

ADDRESS:

REFERRING WORKER:

Title: _____

Phone: _____ **FAX No.:** _____

() _____ () _____

Signature: _____

Date completed: _____

NAME OF APPLICANT:

SS #:

**AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL HIV RELATED INFORMATION**

Confidential HIV (Human Immunodeficiency Virus) related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related without a release form by calling the HIV Confidentiality Law Hotline at 1-(800)962-5065.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form to obtain housing and you can change your mind at any time. If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212)566-5493. These agencies are responsible for protecting your rights.

Name and address of facility/provider obtaining release:

Name of person whose HIV related information will be released:

Name and address of Person(s) who will be given HIV related information:

**NYC Human Resources Administration
Adult Protective Services**

**Voluntary and Proprietary Homes for Adults
400 8th Avenue, 8th fl, NY, NY 10001**

Reason for Release of HIV related information:

Housing Assessment and Placement Approval

Time during which release is authorized:

Six months from date that release is signed.

I authorize the disclosure of HIV related information to the people/agencies listed on this form, and for the reason(s) listed on the form. My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

Date: _____ | _____ | _____ Signature: _____

Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid (Effective January 1, 2017)

The Human Resources Administration (HRA) provides a shelter allowance and a personal needs allowance so that low-income aged or disabled adults who need a supervised and supportive living arrangement can afford housing in state licensed homes and residences. The type of care that is offered in these homes and residences is known as congregate care. HRA provides an allowance for each individual receiving care in a Level 1, Level 2, or Level 3 certified congregate care facility who files an application and is deemed eligible for Cash Assistance (CA). The allowance is based on the rates provided for care and maintenance under the Supplemental Security Income (SSI) Program for SSI beneficiaries residing in the same facility, less the amount of any personal needs allowance included in the SSI rate. There are three (3) levels of congregate care facilities, each with a different rate of payment. These rates change each year in accordance with the Cost of Living Adjustment (COLA) received by SSI recipients.

Congregate Care Level	Shelter Type Code	Description	Semimonthly Shelter Rate	Semimonthly Personal Needs Allowance
Level 1	15	Family-type homes for adults licensed by the Office of Children and Family Services (OCFS), Office of Mental Health (OMH), or Office for People with Developmental Disabilities (OPWDD) and operated by HRA through the Division of Voluntary and Proprietary Homes for Adults (DVPHA). These are smaller residential programs serving people with developmental disabilities, the mentally ill, and the frail elderly. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	\$430.00	\$70.50
	28	Same as above in a rest of the state facility.	\$411.00	
Level 2	16	Adult homes licensed through the New York State Department of Health (DOH) and community residences licensed through OMH. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	\$503.50	\$81.50
	29	Same as above in a rest of the state facility.	\$488.50	
	31	Residential Alcohol and Substance Abuse Treatment Programs. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	\$503.50	
	32	Same as above in a rest of the state facility.	\$488.50	
	43	Community residences licensed through OMH/OPWDD. These are principally small group homes and supported apartments. Cases that were previously coded as Shelter Type 16, but live in an apartment-like setting and are now coded as Shelter Type 43. The case can be larger than a family size of 1.	\$503.50	
Level 3	42	DOH Adult Homes and Enriched Housing facilities. The case must be a family size of 1.	\$617.50	\$97.00