



HUD-VASH RESOURCE GUIDE

for Permanent Housing
and Clinical Care



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This Department of Housing and Urban Development and Veterans Affairs Supportive Housing (HUD-VASH) Resource Guide for Permanent Housing and Clinical Care is designed to provide case managers, and others who work with homeless Veterans in HUD-VASH, with a comprehensive set of resources including useful tools, exercises, worksheets, and helpful links to assist in addressing the multifaceted and complex housing, clinical, treatment, and psychosocial needs of homeless Veterans.

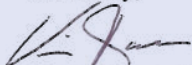
Consistent with Secretary Eric Shinseki's goal of ending Veteran homelessness, VA's Strategic plan to Prevent and End Veteran Homelessness and *Opening Doors*, the Federal Strategic Plan to Prevent and End Homelessness, the Department of Housing and Urban Development and Veterans Affairs Supportive Housing (HUD-VASH) program represents a unique and collaborative partnership between VA, HUD. A key component of HUD-VASH is VA's case management services. These services are designed to facilitate the attainment of the Veteran's recovery goals by supporting stability in safe, decent and affordable permanent housing. While VA provides case management services, HUD provides permanent housing subsidies to Veteran participants and their immediate families by allocating rental subsidies from its Housing Choice Voucher (HCV) Program.

The Resource guide is a product of the VA National Center on Homelessness among Veterans and was developed by a dynamic team of researchers, policy analysts, public health experts, psychologists, physicians, and social workers located throughout the country. Particular thanks and recognition goes to Howard Burchman, Suzanne Wagner and Andre White (Housing Innovations LLC), and the Corporation for Supportive Housing for their extensive contributions to this first edition. see Contributing Authors section for a full list of contributors

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I hope that you find the information contained in this first edition *Resource Guide* to be useful in your day-to-day work with Veterans.

Sincerely,



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A Guide to Using the HUD-VASH Resource Guide

Part 1 Introduction: A Guide to Using the HUD-VASH Resource Guide

This HUD-VASH Resource Guide for Permanent Housing and Clinical Care was developed to provide a resource for those who serve our country's most vulnerable and chronically homeless Veterans through the HUD-VASH Program. HUD-VASH is a critical element of the VA's Five Year Plan to End Veteran Homelessness and of Opening Doors: Federal Strategic Plan to Prevent and End Homelessness.

Part 1 of the *HUD-VASH Resource Guide for Permanent Housing and Clinical Care* is a guide to the program that includes Veteran eligibility, program management, and housing stabilization work with landlords and housing authorities. Part 2 provides an overview of evidence-based practices for HUD-VASH and includes Housing First; coordination with clinical services; understanding trauma and violence; and accessing benefits, education, and employment. Since the issues of housing, mental health, and addiction are interrelated, you will see some overlapping interventions used for simultaneous treatment of a multitude of issues. For example, Motivational Enhancement Therapy, Motivational Interviewing, and Critical Time Intervention are described in both Part 1 and Part 2.

The *HUD-VASH Resource Guide for Permanent Housing and Clinical Care* is a comprehensive guide to implementing a HUD-VASH program. It covers every aspect of HUD-VASH and related practices and programs. Knowing where to begin may seem overwhelming at first glance. In order to help you approach the *Resource Guide* in a way that is most useful to you, we have provided the following self-administered quizzes. The quizzes are customized for each of the key VA members of any HUD-VASH team: Supervisors, Case Managers, and Peer Support Specialists. We encourage you to complete the quiz that most closely matches your role on the HUD-

VASH team. This will provide you with a baseline for your own understanding of HUD-VASH. Each quiz has an answer key that offers recommended chapters to read. Use these suggested readings to develop your own personalized curriculum.

We hope you will find the toolkit useful in your everyday work with your clients and appreciate all of the work that you do to help move homeless Veterans off the streets and into secure and stable housing.

Quiz Instructions

- 1) Choose the quiz for the role that most closely matches your role on the HUD-VASH team. (You might also choose to take more than one quiz to more broadly test your familiarity with HUD-VASH.)
- 2) Take the quiz, noting your answers in writing.
- 3) Locate the corresponding answer key for your quiz and assess your results.
- 4) Start your reading of the Resource Guide with the chapters that are suggested for questions that you may have answered incorrectly.
- 5) Review other sections of the Resource Guide that are suggested readings for items that you may have answered correctly but weren't completely sure about. Consider additional reading even for those questions that you answered correctly to ensure a full understanding of the topic area covered in the quiz for your particular role in HUD-VASH.
- 6) Review other sections of the Resource Guide for the most comprehensive understanding of HUD-VASH.

Baseline Quiz for Supervisors

- 1) Which of the following are the primary targets for HUD-VASH?
 - a. Chronically homeless Veterans
 - b. Veterans who are at risk of being evicted from their housing
 - c. Veterans returning from OIF/OEF
 - d. Veterans leaving the Grant and Per Diem program
 - e. All of the above
- 2) True or False: Veterans with untreated mental illness and addiction issues will fail in HUD-VASH because there is no “carrot” of receiving housing after meeting recovery goals.
- 3) Which of the following describes a key purpose of supervision and training in HUD-VASH?
 - a. To ensure that program staff have sufficient clinical knowledge
 - b. To make administrative program improvements
 - c. To provide support to staff as they encounter obstacles and experience setbacks in their work
 - d. All of the above
- 4) True or False: One example of a HUD-VASH team meeting is a case conference where challenging issues with clients can be raised and discussed.
- 5) Which of the following is NOT the primary responsibility of a Peer Support Specialist on a HUD-VASH team?
 - a. Sharing personal accounts of recovery
 - b. Helping Veterans access free and low-cost community resources
 - c. Conducting a housing and services needs assessment
 - d. Accompanying Veterans to clinical appointments
- 6) True or False: It is the local housing authority’s responsibility to ensure that participating landlords are content with the HUD-VASH Program.
- 7) HUD-VASH Housing Choice Vouchers expire after how many days?
 - a. 30
 - b. 60
 - c. 90
 - d. 120
 - e. They do not expire.
- 8) Trauma refers to the experience, threat, or witnessing of physical harm. Which of the following describes a trauma that a HUD-VASH Veteran may have experienced?
 - a. Military combat
 - b. Childhood abuse
 - c. Military sexual abuse
 - d. Terrorist attack
 - e. All of the above
- 9) Motivational Enhancement Therapy (MET) is a brief therapy based upon the Motivational Interviewing (MI) approach to counseling. MET is designed to enhance client motivation by helping clients to resolve their ambivalence about addressing and ultimately changing their problem behaviors. The fundamentals of MET can be remembered through the acronym OARS. Which of the following is NOT an example of the fundamental skills of MET? Do you know the correct skill to complete the acronym?
 - a. Open-ended questions
 - b. Affirmations
 - c. Resisting negativity
 - d. Summarizing

- 10) True or False: Research has not been able to reliably distinguish those who will or will not succeed in employment.

Answer Key: Baseline Quiz for Supervisors

#	Answer	Suggested Toolkit Reading
1	A: HUD-VASH is designed to serve our country's most vulnerable veterans, many of whom are chronically homeless (disabled with extended periods of homelessness). This may include some OEF/OIF Veterans, but they are not the primary target population for HUD-VASH. Many OEF/OIF may be served through VA's new Homeless Prevention program, Supportive Services for Veteran Families	Part 1, Chapter 3 Provides eligibility requirements and instructions for determining if HUD-VASH is the right program for a Veteran
2	FALSE: Fortunately for staff, providing a Veteran who is homeless with a rent-subsidized furnished apartment with few strings attached serves as an excellent way to achieve trust and begin a healing, collaborative relationship.	Part 2, Chapter 9 Explains the principles of Housing First
3	C: To provide support to staff as they encounter obstacles and setbacks in their work. Program staff should ensure good communication with clinical providers, but they do not have primary responsibility for clinical knowledge. Administrative program improvements are best addressed by a project team consisting of 6-10 members.	Part 1, Chapter 7 Will outline supervision in HUD-VASH
4	FALSE: Team meetings are different from case conferences in that they focus more on the administrative and systemic issues that arise in the work. They offer opportunities for staff to share resources and best practices while engaging in team building.	Part 1, Chapter 7 Outlines the roles and responsibilities of the HUD-VASH team
5	C: It is the primary responsibility of the Case Manager to conduct the Housing and Services Needs Assessment. The Peer Support Specialist may support the Case Manager in doing so.	Part 2, Chapter 8 Will tell you everything you ever wanted to know about incorporating peer support into your team
6	FALSE: Regular meetings with landlords are critical parts of the Case Manager's responsibilities in housing stabilization.	Part 1, Chapter 6 Provides important information about the unique focus on housing stabilization in HUD-VASH

7	D: 120 days. Standard Housing Choice Vouchers expire after 60 days, but HUD-VASH vouchers are automatically extended to 120 days. Veterans with disabilities may request an extension beyond 120 days if their disability is impairing their ability to find housing.	Part 1, Chapter 4 Provides details about Housing Choice Vouchers and working with your public housing authority partners
8	E: All of the above. It is important for the HUD-VASH team to be educated in Trauma Informed Care (TIC) because of the myriad of possible traumas homeless Veterans may have experienced in their lives.	Part 2, Chapter 5 Has great information for making sure your HUD-VASH team provides TIC
9	C: The fundamental skills of MET can be remembered through the acronym, OARS: Opened-ended questions; Affirmations; Reflective listening; and Summarizing.	Part 2, Chapter 2 Describes the treatment approaches for mental illness and drug dependency
10	TRUE: The guiding principle behind employment for HUD-VASH participants is that everyone who wants to work or learn should be encouraged and supported in that endeavor.	Part 2, Chapter 6 Offers guidelines for linking to and providing employment & education services

Baseline Quiz for Case Managers

- 1) The starting point of a Housing First approach to HUD-VASH case management is to ask the Veteran a number of questions that will put him or her in a decision-making role by soliciting information about his or her housing needs. Which of the following is NOT a good example of a question that puts the Veteran in the decision-making role?
 - a. Would you like a studio or one-bedroom apartment?
 - b. Why do you feel you are ready to live in an apartment?
 - c. Are there other people in your life that you want to live with?
 - d. What type of household items do you need?
 - e. All of these questions put the Veteran in a decision-making role.
- 2) True or False: In HUD-VASH, it is the landlord's responsibility to educate the Veteran about expectations of tenancy and maintaining a home.
- 3) True or False: Veterans are expected to attend regular meetings with Case Managers at the VA.
- 4) Which of the following is NOT an important time to reach out and connect with a Veteran's landlord?
 - a. Upon initial move-in
 - b. On the 10th of each month
 - c. When the Veteran is experiencing behavior changes
 - d. When you cannot reach the Veteran after repeated attempts to visit his or her apartment
 - e. All of the above are important times to connect with landlords.
- 5) All HUD-VASH participants must be linked to a Patient Aligned Care Team (PACT) within the VA. Which of the following is NOT true about PACTs?
 - a. They include 1-3 primary care providers, an RN, LPN, health technicians, and nursing assistants.

- b. The teams are augmented by social workers, nutritionists, pharmacists, and behavioralists.
 - c. They serve as a first stop for urgent or emergent medical needs.
 - d. They reduce emergency department visits and preventable hospitalizations.
 - e. All of the above are true.
- 6) True or False: Case managers should not help Veterans find a job until they are in recovery.
- 7) Home visits are key interventions that help prevent housing crises before they occur. Which of the following is NOT a good practice for home visits?
- a. Check for hoarding and other unsanitary conditions.
 - b. Check utility connections.
 - c. Surprise the Veteran occasionally to find out what's really going on in the Veteran's apartment.
 - d. Look for evidence of non-lease holders that may be living in the unit.
 - e. All are good practices for home visits.
- 8) Which of the following is true about the "Total Tenant Payment?"
- a. It is generally 30% of a Veteran's adjusted income.
 - b. It includes both rent and utilities.
 - c. It is paid to the landlord.
 - d. It is calculated by the housing authority.
 - e. All of the above.
- 9) Risk factors for partner violence include which of the following?
- a. A history of previous abuse
 - b. Victimization
 - c. Criminal history
 - d. All of the above
- 10) True or False: While relatively non-specific, sleep is often one of the earliest signs of a worsening in one's mental state.

Answer Key: Baseline Quiz for Case Managers

#	Answer	Suggested Toolkit Reading
1	B: The Housing First approach does not question readiness to live in housing. It assumes that the Veteran has a right to housing. The Case Manager's questions should be focused on understanding the housing features in which the Veteran is interested.	Part 2, Chapter 9 Explains the principles of Housing First
2	FALSE: In HUD-VASH, the Case Manager has the primary responsibility for educating the Veteran about expectations of tenancy and maintaining a home. This is an integral, ongoing facet of a case management approach that is based in housing stabilization.	Part 1, Chapter 6 Provides important information about the unique focus on housing stabilization in HUD-VASH

3	FALSE: Case Management is provided in the home as well as agency offices and other community settings. Once a Veteran is housed, the Case Manager is consistently monitoring for and assisting the Veteran with problems that can jeopardize ongoing tenancy. In the initial months of tenancy, the case manager should make regular home visits -weekly at first- to make sure that the transition is going smoothly.	Part 1, Chapter 5 Is your guide to Case Management: The Key to HUD-VASH Success
4	E: All of the above are important times to connect with landlords. If no issue is occurring, a check-in on the 10 th of each month is most helpful because this is when landlords issue "10 day notices to comply or vacate" for issues other non-payment of rent.	Part 1, Chapter 5 Is your guide to Case Management: The Key to HUD-VASH Success
5	E: All of the above are true.	Part 2, Chapter 4 Explains the integration of Case Management with Primary Care
6	FALSE: The guiding principle behind employment for HUD-VASH participants is that everyone who wants to work or learn should be encouraged and supported in that endeavor.	Part 2, Chapter 6 Will help you provide services and link Veterans to supported education and employment
7	C: Surprise home visits should only be done if there are concerns that a client is in danger or hurt and only after all other ways to contact the client have been exhausted.	Part 1, Chapter 5 Is your guide to Case Management: The Key to HUD-VASH Success
8	E: All of the above. It is important for Case Managers to have a clear understanding of the way housing choice vouchers work in HUD-VASH.	Part 1, Chapter 4 Provides details about Housing Choice Vouchers and working with housing authority partners
9	D: All of the above. Case Managers are well-placed to be the "first responders" to address family issues, broadly, and partner violence, specifically.	Part 2, Chapter 7 Explains violence and partner violence among Veterans
10	TRUE: The Case Manager can bring significant value to the treatment process by making observations in the field that might otherwise go unnoticed.	Part 2, Chapter 3 Shows you how Case Management integrates with Mental Health Services

Baseline Quiz for Peer Support Specialists

- 1) True or False: In HUD-VASH, the housing is tied directly to treatment. If a Veteran does not comply with treatment, s/he will likely lose housing privileges.
- 2) Which of the following is true about the role of a Peer Support Specialist (PSS) in a HUD-VASH program?
 - a. The PSS is usually a volunteer.
 - b. The PSS is an untrained staff member that assists other members of the team.
 - c. The PSS's primary responsibility is to assist Veterans with getting to appointments.
 - d. The PSS is a full member of the staff team who participates in HUD-VASH team meetings and clinical case conferences.
- 3) Which of the following entities pays rent to landlords in HUD-VASH?
 - a. Housing authorities
 - b. VASH supervisors
 - c. Veterans
 - d. VASH Case Managers
- 4) True or False: Veterans are allowed to decline involvement with a HUD-VASH Peer Support Specialist if they choose.
- 5) Veterans with disabilities who are interested in taking classes can qualify for educational accommodations. Some examples of these accommodations include
 - a. Being allowed to tape record classes.
 - b. Being provided both with written and verbal instructions.
 - c. Extended time for test taking.
 - d. Access to quiet spaces for test-taking .
 - e. All of the above.
- 6) True or False: Peer Certification means that the Peer Support Specialist can perform case management.
- 7) True or False: Because HUD-VASH Veterans have been homeless for long periods of time, many will need a harsher, confrontational style when dealing with substance use disorders.
- 8) True or False: The goal of Relapse Prevention is to teach the Veteran how to anticipate and cope with "triggers" such as moods, thoughts or situations that increase the risk of using.
- 9) A key role for a PSS is to lead groups for Veterans. Which of the following is NOT a good example of a PSS-led group:
 - a. Unstructured peer support groups
 - b. Vet-to-Vet groups
 - c. AA/NA groups
 - d. AA groups
 - e. All of the above are good examples of PSS-led groups.
- 10) Which of the following is NOT a typical Peer Support Specialist activity on a HUD-VASH team?
 - a. Advocating for Veterans on their caseload
 - b. Sharing personal wellness and relapse prevention strategies
 - c. Taking Veterans to their favorite place of worship
 - d. Helping Veterans with job applications
 - e. None of the above is a typical activity for a Peer Support Specialist.

Answer Key: Baseline Quiz for Peer Support Specialists

#	Answer	Suggested Toolkit Reading
1	FALSE: In HUD-VASH, housing loss occurs only for lease violations, not for treatment non-compliance or hospitalization.	Part 2, Chapter 9 Explains the principles of Housing First
2	D: The Peer Support Specialist is a paid, trained member of the HUD-VASH team with many important roles.	Part 2, Chapter 8 Is your guide to Peer Support in HUD-VASH
3	B & D: The Veteran pays approximately 30% of their income to the landlord, and the Housing Authority pays the remainder up to a pre-determined amount.	Part 1, Chapter 4 Provides details about Housing Choice Vouchers and working with your housing authority partners
4	TRUE: The Housing First approach puts the Veteran at the center of decision-making.	Part 2, Chapter 8 Is your guide to Peer Support in HUD-VASH
5	E: All of the above. Many Veterans, especially young adults returning from the OIF/OEF conflicts will have an interest in using their GI Bill benefits to further their education.	Part 2, Chapter 6 Will help you provide services and link Veterans to supported education and employment
6	FALSE: Peer Certification means that PSS services are reimbursable by state Medicaid programs.	Part 2, Chapter 8 Is your guide to Peer Support in HUD-VASH
7	FALSE: Use of a harsh confrontational style can backfire when working with people who have had trauma that occurred under conditions of harsh confrontation.	Part 2, Chapter 5 Will help you learn the importance of Trauma-Informed Care
8	TRUE: Understanding treatment approaches can help PSSs reinforce the work Veterans have done with any other treatment providers they may have.	Part 2, Chapter 2 Describes Treatment Approaches for Mental Illness and Chemical Dependency
9	E: All of the above. PSSs should consult with their colleagues, supervisors, and Veterans about which groups would be the most useful to lead in a particular HUD-VASH program.	Part 2, Chapter 8 Is your guide to Peer Support in HUD-VASH
10	C: Advocacy, sharing personal experiences, and assisting with employment and education are all examples of activities that a Peer Support Specialist might engage in.	Part 2, Chapter 8 Is your guide to Peer Support in HUD-VASH

Overview of the HUD-VASH Program

What's in This Chapter?

HUD-VASH is a unique partnership between the Department of Veterans Affairs (VA) and the Department of Housing and Urban Development (HUD) that provides long-term case management, supportive services, and permanent housing support for chronically homeless Veterans. Using a Housing First approach, the HUD-VA Supportive Housing (HUD-VASH) program combines Housing Choice Voucher (HCV) rental assistance with case management and clinical services provided by VA.

In this chapter you will learn

- Who is eligible for HUD-VASH;
- The structure of the HUD-VASH program;
- Basics about housing vouchers;
- Basics about HUD-VASH VA services; and
- The process by which a Veteran moves from chronic homelessness to housing stability as part of the HUD-VASH program.

What is HUD-VASH?

In 1992, VA and HUD established the HUD-VASH program to serve the neediest, most vulnerable homeless Veterans and their immediate families. VA provides case management and eligibility screening services, while HUD allocates permanent housing subsidies from its "Housing Choice" program. The primary goal of this joint program is to move Veterans and their families out of homelessness.

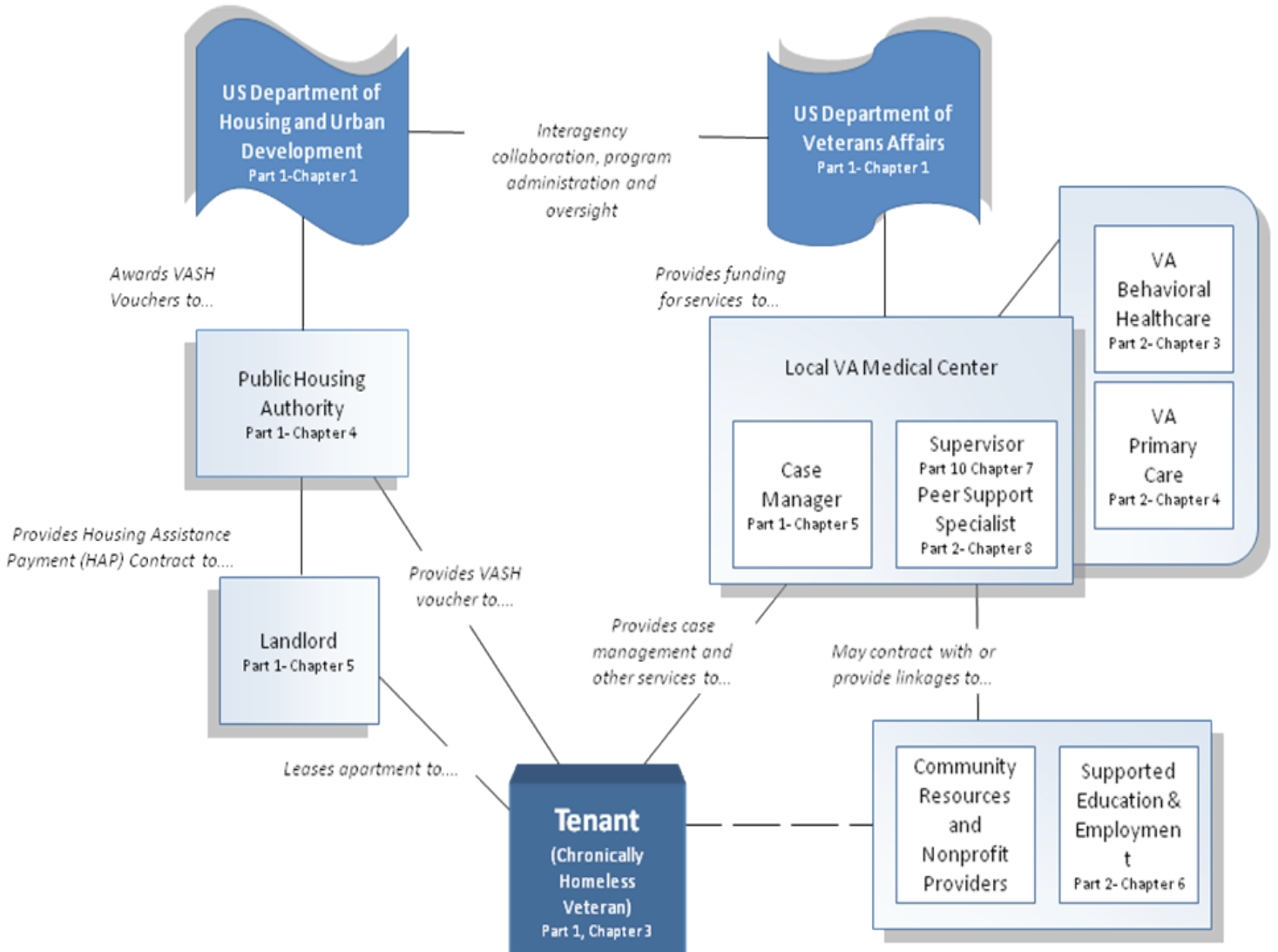
A key component of the program is VA's case management services. These services are designed to improve the Veteran's physical and mental health and enhance the Veteran's ability to live in safe

and affordable permanent housing of his or her choosing. Case management services promote housing stability and support recoveries from physical and mental illnesses and substance use disorders. As the program's primary goal is to end homelessness and promote housing stability, HUD-VASH does not require a set period of sobriety in order for a Veteran to be considered eligible for the program, nor does non-compliance with HUD-VASH case management services necessarily lead to loss of the housing voucher. However, it is expected that a Veteran remain in case management, even with possible fluctuations in the Veteran's living situation and treatment participation. Thus, a Veteran enrolled in HUD-VASH who relapses to substance abuse and re-enters treatment would not necessarily be discharged from HUD-VASH case management; in fact, such case management provides important continuity of care and an opportunity to assist the Veteran in his or her recovery.

"Case management provides important continuity of care and an opportunity to assist the Veteran in his or her recovery."

Every Veteran enrolled in the HUD-VASH program is assigned a Case Manager. Together, they develop a Housing Stabilization Plan, a recovery-focused plan that identifies housing needs and sets treatment goals requiring active participation from the Veteran. In order to be successful, the Housing Stabilization Plan must reflect each Veteran's individual needs. The Veteran and the Case Manager will review and revise the Housing Stabilization Plan on a regular basis to meet the changing clinical and psychosocial needs of HUD-VASH clients. It is critical that the Veteran client participate in this process and endorse each iteration of the Housing Stabilization Plan.

HUD-VASH Program Structure



Who is eligible for HUD-VASH?

There are two components to HUD-VASH program eligibility – VA requirements and Public Housing Authority (PHA) guidelines.

Veterans meet VA requirements when they

- Are eligible for VA Health Care Services,
- Require case management services in order to obtain and sustain independent community housing, and
- Meet the McKinney-Vento Act definition of homelessness by either
 - ◆ Lacking a fixed, regular, adequate nighttime residence, or
 - ◆ Identifying as his or her primary residence a shelter, welfare hotel, transitional or temporary housing facility, or public or private place not designed for, or ordinarily used as, a regular sleeping accommodation.

The full definition of homelessness as used by the HUD-VASH program can be found at http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/lawsandregs/mckv

The HUD-VASH program targets VA's most vulnerable homeless Veterans, including those with medical, mental health and or substance use disorders. Its primary target population is the Veteran who has experienced multiple episodes of homelessness, is suffering from mental health and/or medical complications, has been homeless four or more times in the prior three years, or who has been continuously homeless for one year or longer.

VA considers both single Veteran applicants and Veterans with dependent family members. However, since HUD-VASH is designed for the homeless Veteran, the household must include the eligible Veteran and cannot include any family members with a Lifetime Sexual Offender Registry status.

The PHA guidelines become important once the Veteran's eligibility has been favorably determined by VA and he or she is approved by the HUD-VASH Case Manager. At that time, the Veteran must complete a PHA application and follow the PHA's guidelines to obtain housing. The PHA will expect

proof of a qualifying income level, and will also expect participating Veterans to follow the landlord's tenancy expectations.

What does "recovery" mean?

Recovery, as part of HUD-VASH, is defined as *"any type of work put into achieving independent living and community stability by actively addressing areas that have contributed to, or have been concurrent with, homelessness."* Recovery requires an assessment of the Veteran's life, including areas that have been affected by the identified problem(s), and creates a progression toward restoring elements that are most significant to the Veteran. Recovery includes not only the things that must be done to resolve physical ailments, mental illnesses, and substance use disorders, but also the problems that have arisen from these issues. It also includes things such as getting involved in activities in the community that are of interest to the Veteran – examples include attending cultural events, volunteering, participating in church activities, or exercising.

How long does it take to obtain housing?

Length of time will vary depending on the Veteran's history, the area where housing is being sought, availability of landlord housing stock, and the landlord's willingness to rent to individuals with a Housing Choice Section 8 voucher. Issues such as credit history may also impact the amount of time it will take to obtain housing.

Where can Veterans in HUD-VASH live?

Because Veterans enrolled in HUD-VASH must participate in case management by a VA HUD-VASH Case Manager in order to retain the housing voucher, proximity to VA services should be a primary consideration, as lack of participation may result in PHA invalidating use of the voucher. Therefore, Veterans must live within a reasonable distance from a VA facility—so that both the Case Manager and the Veteran can easily travel back and forth without any undue travel burden. Although level of service

intensity will ultimately be determined by the Veteran's needs, HUD-VASH clients can expect active participation in case management to require three contacts per month. These contacts will occur when Case Managers visit the Veteran at home and when the Veteran travels to the VA facility for primary care and specialty care as indicated. HUD-VASH Veterans can live anywhere they are able to consistently meet these requirements.

What is portability and what does it mean for the Veteran?

Portability allows a Veteran to live outside of the jurisdiction of the PHA where the vouchers were allocated, within certain limits. Portability can allow a Veteran to live in a suburb or small town outside of the immediate area where the VA facility is located. However, since Veterans in the HUD-VASH program must have VA HUD-VASH Case Managers, and must participate in the case management program, the Veteran must still live within a reasonable traveling distance to the facility where the Case Manager is located without causing significant travel burden. After meeting this requirement, Veterans may live in any apartment or other housing unit that meets PHA standards, is affordable with the voucher, and has a landlord willing to rent to the Veteran.

Unlike many Section 8 vouchers, which require residence in an initial area for a year or more, HUD-VASH vouchers are portable from the beginning, which allows the Veteran the flexibility to choose a suitable community from the outset.

It is also possible for the Veteran to move outside of their original VA's service area. In this case, the original HUD-VASH Case Manager should help the Veteran determine if it is possible to enter into the HUD-VASH program in the new service area. The VA where the Veteran wishes to live must have 1) an open or vacant voucher for the Veteran to use, and 2) the ability to provide the necessary case management services outlined in the Veteran's Housing Stabilization Plan. Thus, HUD-VASH programs must work together to plan and arrange the move, and the Veteran must also have the resources to move.

What services do Veterans receive in the HUD-VASH program?

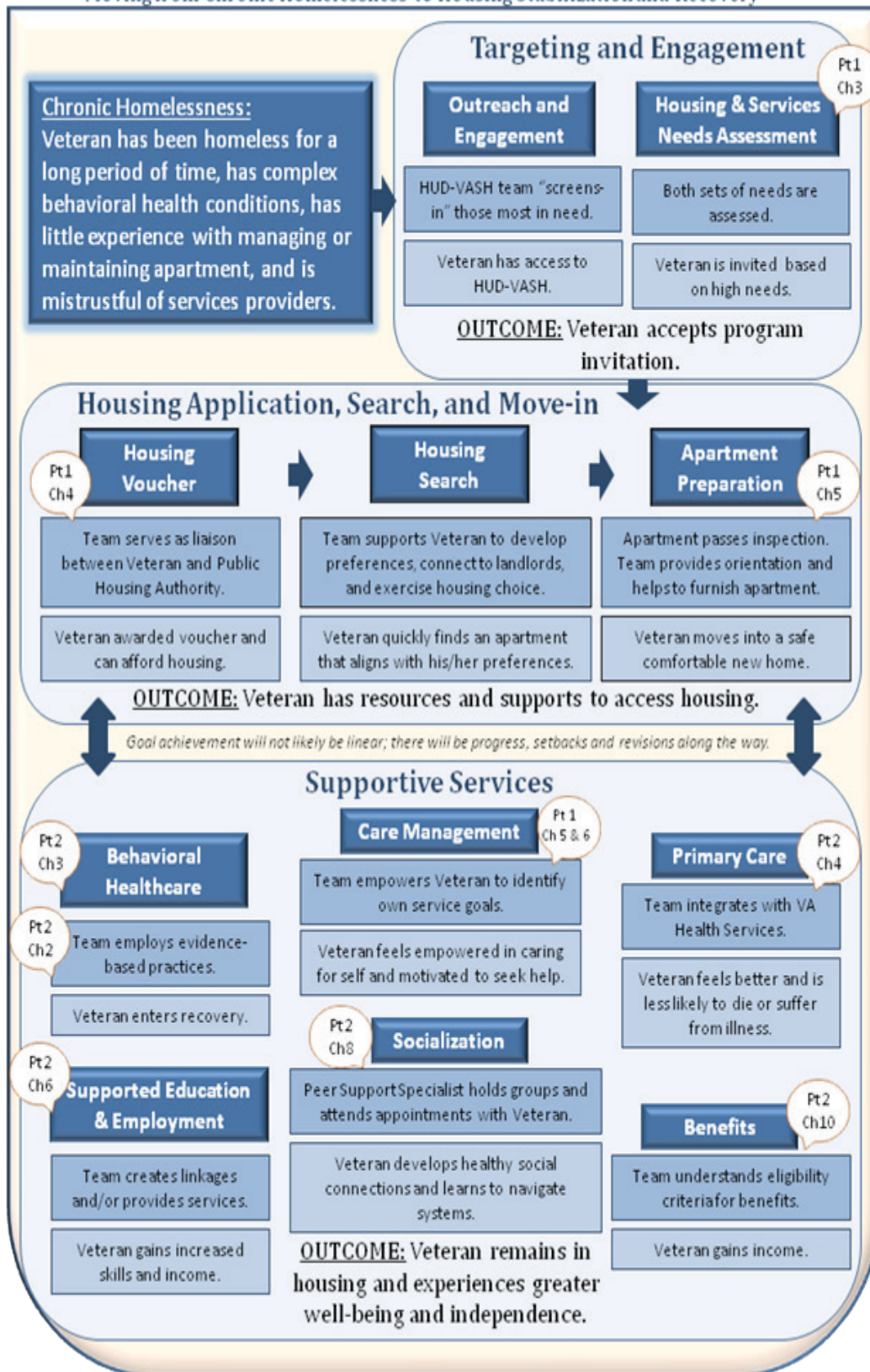
Veterans are offered the services they need for recovery from homelessness. This includes referrals to VA primary care as well as services, including mental health or substance abuse treatment services, income assistance, employment supports, disability benefits, and credit repair and skills for money management. HUD-VASH Case Managers will help the Veteran locate and secure housing, navigate PHA procedures, agree to a tenancy contract, and plan the move. Skill training, clinical assessments, advocacy, and linkages to other community supports and service providers may also be provided. After housing is secured, the Veteran may receive assistance with landlord and PHA procedures, planning for the move, and community re-introduction—as he or she reconnects with family and friends, finds cultural opportunities, explores spiritual organizations, and develops new interests, activities, and relationships. Case management services are intended to be available for the Veteran after being housed—assisting with adjustment to the community and maintaining connections to needed treatment, benefit and vocational services. Intensity and frequency of services are adjusted based on the unique needs of the Veteran. Services should be provided in the Veteran's home at least monthly.

How long does the HUD-VASH program last?

HUD-VASH lasts as long as the Veteran needs the program to last. The time is variable and depends on the Veteran's functional and economic abilities. Veterans who no longer need case management to function, yet feel they need to continue with the voucher portion of the program, may work with their Case Manager to discontinue case management. If the Case Manager agrees that case management is no longer needed, then the Veteran can stop this portion of the program but continue with the voucher without penalty.

HUD-VASH Theory of Change

Moving from Chronic Homelessness to Housing Stabilization and Recovery



Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your basic knowledge about HUD-VASH.

- 1) The HUD-VASH program was designed to meet the needs of the most vulnerable homeless Veterans.
- 2) HUD-VASH eligibility is based on a number of housing readiness factors.
- 3) Families are eligible for HUD-VASH.
- 4) Recovery, for this program, means working toward maintaining housing and community stability by actively addressing the areas that have contributed to homelessness or have been concurrent with homelessness.
- 5) Housing vouchers expire in one month and cannot be transferred to other jurisdictions.

How to Develop a HUD-VASH Project Plan

What's in This Chapter?

In many ways, implementing HUD-VASH creates a need for change to current program practices. Making these changes requires a project plan and oversight by a project team.

In this chapter you will learn

- How to form a project team,
- How to develop a project quality improvement plan, and
- How to monitor the project and continuously improve the program.

After reading this chapter, you will be able to pursue a concrete process of translating ideas into practice, thereby maximizing the quality of your HUD-VASH program.

Introduction to Using this Resource Guide

As you read through the following chapters of the *HUD-VASH Resource Guide for Permanent Housing and Clinical Care*, you will see descriptions of practices that you are already using. You may also read about practices that are different from how your individual program currently operates. There are *Key Practices* sections at the end of chapters 4 through 8 which summarize the major practice recommendations from each chapter. Give special consideration to practice recommendations that differ from your current practice. Our hope is that some of the differences between this *Resource Guide's* description of practices and your current practices will spark ideas about how your program could be improved. Ideas for program improvement are wonderful; however, ideas do not benefit the lives of the Veterans we serve until they are

brought into practice. The purpose of this chapter is to provide you with a concrete process that your particular HUD-VASH program can follow in order to bring these ideas into practice. This process includes forming a project team to identify areas for improvement, create an action plan, monitor the project, and establish a process to continually improve the program.

Form a Project Team

While individual Case Managers may be able to implement some of the ideas in this *Resource Guide* on their own, significant improvement in your program will only occur if changes are implemented systematically across your program. Changing how an entire program functions is not an easy task. Thus, we strongly recommend the formation of a project team to take on this task. Appointing a project team and giving them a mandate to implement program improvements creates accountability that increases the chances that changes will actually occur. It also spreads the work of changing a program over a number of staff members so that no single staff member is overburdened with the effort.

Your project team should be large enough so that the work can be divided up in pieces that will not be overly burdensome on team members, but small enough that every team member can meaningfully participate. Groups with six to ten members generally work well. Teams that are much larger than this tend to be less efficient. It is always possible to break teams into smaller sub-groups to tackle smaller tasks. You may need to bring more people into the team once you are underway or replace some individuals who will naturally become less involved as the project evolves.

When considering the makeup of your team, look for a good mix of thinkers and doers. It is helpful to include staff with a range of experience. More experienced staff members have more knowledge of how your program currently operates and will better understand the resources and constraints within your VA. Newer staff members, however, bring new perspectives and see new possibilities. Newer staff members also gain valuable skills working alongside more experienced colleagues. To form a team that is enthusiastic and motivated, recruiting volunteers is preferable to assigning a team.

Once team members have been selected, leadership roles should be decided. We recommend designating a chair to set meeting agendas and facilitate meetings. You may also want to designate an assistant chairperson to lead in the chairperson's absence and a secretary to take and distribute meeting minutes.

Establish a Team Process

Once your team is formed, it should meet regularly. We recommend meeting every two weeks. Meeting less frequently than this tends to undercut momentum. Meeting more frequently tends not to be productive because team members have not had time to do enough work to merit discussion. There may be periods during the project where it may make sense to meet more or less often depending on circumstances. A regular meeting time cuts down on time spent scheduling meetings and helps ensure that staff will be available to meet.

Building accountability into your team process is important for keeping your project moving. Without accountability, team members will end up putting time into their other work responsibilities for which they *are* accountable. There are several ways to build in accountability. One way is to have the team announce their project goals to program leadership, the entire staff, and/or the administration. The more public the announcement is, the more accountable staff will be for meeting those goals. Another important accountability tool is meeting minutes. Meeting minutes help keep track of who agreed to do what, by when, and foster accountability within the team. They also help keep team members who

miss meetings up to date. Finally, it is helpful to have a mechanism for staff to report the team's work to program leadership on a regular (monthly) basis. This can either be an oral update given at a regularly scheduled meeting and/or brief written reports submitted at regular intervals.

Choose a Focus

It is not possible to change everything at once. In fact, it is often more effective to start small and build upon success. This *Resource Guide* may provide you with many ideas on how your program could be improved. We recommend that you choose only one or two changes to implement initially. Once these changes are successfully up and running, you can then move on to other improvements. This process of identifying areas for improvement and then implementing changes to address these areas can become an ongoing part of your program. Such a process is called Continuous Quality Improvement (CQI) and is a requirement for CARF accreditation.

It may be that after reading the *Resource Guide*, your program's staff clearly agrees on what programmatic change would be most beneficial to the Veterans in your HUD-VASH program. If so, we encourage you to trust the collective wisdom of your staff. If there is no consensus among your staff, we encourage your project team to think carefully about this before proposing a change. It may be helpful to systematically review each section of this *Resource Guide* and identify discrepancies between your current practices and the recommendations provided throughout this document. These discrepancies may suggest possible program improvements for your project team to consider. Pay particular attention to the *Key Practices* identified at the end of chapters 4 through 8. The **Program Improvement Tool** may be helpful in organizing this information. An example of a completed Program Improvement Tool can be found on the following page.

Once you have compiled a list of potential program changes, you will need to prioritize this list to decide what to address first. You can prioritize each potential improvement using a "high," "medium," "low" scale after considering the following factors:

- **Impact:** What change will yield the biggest positive impact for Veterans served in your program?
- **Evidence base:** What change will help move the program to better match the evidence base?
- **Fit:** Does the practice described in this *Resource Guide* make sense in your VA with the Veterans that you serve? For example, what makes sense in an urban environment may not work in a rural setting.
- **Capacity:** Capacity refers to resources (e.g., staff, skills, training, and facilities). Do you have the resources to devote to making the change? Even with resources, do you have the authority to change the current practice?
- **Difficulty:** Which changes have the highest probability of success? How long will it take to implement each change? Sometimes it is best to accomplish a small goal in order to build momentum for future changes that are more ambitious. We recommend that you pick something for your first project that you are confident you can successfully complete in three months or less.

Record the rationale for your prioritization of each potential improvement so that you can compare rankings and explain them to others.

Program Improvement Tool

Section	Suggestion	Current Practice	Possible Improvements	Priority	Rationale for Priority
Housing Level Case Management	Develop longer term plan – look at non-immediate needs such as education, career goals, social/family reconnections, recovery and wellness	Once Veteran is stabilized in housing, contact with Veteran typically diminishes substantially before a long term plan is firmly in place. Other Veterans with immediate needs take priority, so long term planning never occurs.	Begin discussion of long term goals in Phase 1 to help build Veteran’s motivation for change and growth. Require long term goals in Housing Stabilization Plan. Review these goals and progress towards them in all case conferences.	Medium	This potentially has a big impact for Veterans and is in line with motivational interviewing; however, it will be time consuming for Case Managers and will require supervisor monitoring.
			Create a resource list specifically targeting education and careers to help case managers link Veterans to relevant community resources in these areas.	High	This could be modestly to very helpful for Veterans, depending on the identified resources. Although this involves a modest amount of upfront work and some ongoing work to maintain, it would not add substantially to Case Managers’ workload.

Program Improvement Tool

Section	Suggestion	Current Practice	Possible Improvements	Priority	Rationale for Priority

Create a Plan

Once your team reaches consensus on a project focus, it is important to move quickly into planning. Team members need to see that this project is more than discussion of appealing ideas in an endless series of meetings—that it is a process that can lead to concrete programmatic changes and improvements in Veterans' lives. Teams will remain motivated if these connections are evident and will lose momentum if progress stalls. Detailed plans are important to the success of program improvements. Without them, details can fall through the cracks, reducing the effectiveness of your work. Although planning takes time, it is very important. The time you spend on creating a clear plan saves time and resources later, while also increasing your chances of reaching better outcomes for Veterans. You can

also use a detailed plan to help you monitor what's working or not working well so adjustments can be made to improve your program's functions.

To develop your project plan, you will make a detailed list of all the activities that will need to take place in order to bring about the change. Project activities may include securing additional resources, changing program policies and procedures, recruiting new staff, training staff in an evidence-based practice, etc. For example, if you plan to use Peer Specialists, you will need plans to recruit, train, and supervise these Peers. You may also need to factor in transportation arrangements for activities. Creating a project plan now can help you ensure that you're ready to implement a change. The project plan ensures that you're staying on track. The details of a project plan include

- Descriptions of all types of activities needed to effectively prepare for implementation, including administrative tasks, policies and procedures, training, creation of materials, recruitment, and evaluation
- Timelines and due dates for activities

- Task delegations, including specifying who is responsible for each activity
 - Resource needs and options for obtaining them
- The **Project Planning Tool** on the following page may be helpful in organizing this information.

Project Planning Tool

Activities	By when will this be done? When will this occur?	Who is responsible?	Are any resources needed? Where will you get them?	Date Completed

Monitor Your Plan

The best project plan in the world is only helpful if it is followed. In order to ensure that your project plan is followed, we recommend that you consider how to monitor its implementation before putting it into action. Understanding how well you implemented program changes gives you a more complete picture of whether or not these changes are contributing to better outcomes for the Veterans you serve. It can also show you immediate and important places to make midcourse corrections that will help improve your program's operation.

- Have your team look back at each activity listed in your completed project planning tool and ask
- How will we know if this activity occurred?
- How will we determine whether this activity was performed well?
- When will we monitor this activity?
- Who will be responsible for monitoring this activity?

The answers to these questions do not need to be complicated. For example, meeting minutes and attendance records can be used to verify that

meetings, classes, or trainings took place. Final, approved copies of documents can be used to verify that changes were made to policies and procedures. Many evidence-based practices include fidelity measures that can be used to determine the *success* of a program's implementation. You may also choose to use Veteran satisfaction surveys, interviews, or focus groups with either Veterans or program staff to determine the *quality* with which activities are implemented. The **Project Monitoring Tool** on the following page is helpful for organizing this information.

In addition to monitoring each activity in your plan, it is also important to think about monitoring the impact of your overall project. How will you know whether your project is working overall? What will be the impact on Veteran outcomes? Will your project improve housing stability, employment, sobriety, social support, or Veteran satisfaction with services? Think about the ways in which you will measure its impact, how you will get that information, and how often you should review it to make sure your program is on track.

Project Monitoring Tool

Activities	Monitoring Method	When will monitoring occur?	Who is responsible?

Continuous Quality Improvement

As you monitor the implementation of your project plan, it's important to take time to review the information that you are collecting to see what should be fine-tuned to make things work better.

A common business strategy, called Continuous Quality Improvement, or CQI, can help you do this. Continuous quality improvement means that feedback is collected from evaluation information and considered on a regular basis in order to improve program quality.

A process to review such information should be scheduled at regular intervals. The review meeting should focus on making sense of the data you have collected to monitor your project. The meeting can also focus on problem solving. For example, if you are being prevented from executing an activity in your project plan, you may bring this issue to the review meeting and have members help you brainstorm possible solutions. Another example may be that you get input at these meetings about making a decision on whether to continue or change course following the execution of an activity from the project plan. Consider monthly, in-person reports to program leadership.

In sum, the purpose of these meetings is to

- Find out whether your project plan is on track or in need of revision,
- Make sense of the data collected to monitor your plan and decide on next steps,
- Provide input to fine tune and revise the project plan or tasks along the way, and
- Provide encouragement and recognition to the project team.

Once your project is up and running, your review process should also consider the overall impact of your project. Have Veterans benefited from the changes you have implemented?

Once you have collected information on the project's impact, you are ready to make the decision about its future. There are essentially three options:

- 1) **CONTINUE.** If the results indicate the project is working as hoped, then **CONTINUING** it is the right choice. To do this, it will be important to ensure that the new practices introduced by your project become part of the routine operations of your program. This means you may need to think about
 - Resource availability (are there adequate resources to continue?),
 - Dissemination (how will relevant staff, including future new staff, be made aware of it?), and
 - Training (how do we ensure that staff have all the information they need to make this part of their routine?).
- 2) **MODIFY.** If the new practices showed potential, but did not go exactly as intended (either not totally implemented as planned and/or lacking all the desired impacts), then it may need to be **MODIFIED.** This means that the project team should come together to think about revising the project plan, implementing further changes, and then monitoring and evaluating it again.
- 3) **DISCONTINUE.** If the project was implemented well, but did not have any of the desired impacts, then the right choice may be to **DISCONTINUE** it and try something else altogether. You may want to re-visit the ideas in your completed Program Improvement Tool.

By repeating the process outlined in this chapter, HUD-VASH programs will move their programs closer to the recommended HUD-VASH model described in this guide and, in so doing, realize better outcomes for the Veterans that they serve.

Now that you have an idea of the process to use with this guide, look through the following chapters and consider how your existing program can be improved. Use the Program Improvement Tool on page 20 and in the Appendix to record your thoughts.

Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your knowledge about Creating a Project Plan.

- 1) Appointing a project team prevents any one staff member from becoming overburdened with the effort.
- 2) Groups with 2-3 team members usually work well.
- 3) The project team should be made up of the most experienced staff members.
- 4) Project teams are more successful when staff members volunteer to participate.
- 5) One example of a plan element is task delegation.
- 6) Veteran satisfaction surveys are one way to monitor progress on a project plan.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) Your team may have many program improvements that it would like to make. What are some important steps for prioritizing which will be addressed first?
- 2) Imagine that your team is finding that once a Veteran is housed, long term planning never seems to occur because other Veterans' immediate needs take priority. What possible improvements could your team make to better address long term planning?
- 3) Securing additional resources is one example of an activity that makes program improvements. What are some others?

Is HUD-VASH the Right Program?

Eligibility and Assessment

What's in This Chapter?

HUD-VASH is a limited resource with unique features that enables the VA and HUD to serve the most vulnerable, most needy (in need of long term psychiatric and medical services to maintain housing), and chronically homeless Veterans with tools never before available. Determining which Veterans are best suited for HUD-VASH is an important part of ensuring that these resources go to their highest and best use.

In this chapter you will learn

- Methods for assessing both housing requirements and clinical service needs, including how to conduct a Comprehensive HUD-VASH Assessment;
- HUD-VASH screening criteria;
- Standards for HUD-VASH enrollment; and
- Alternate Veteran-specific housing resources, if applicable.

After reading this chapter, you will have a clear sense of how to “screen-in” those most in need of HUD-VASH. You will also have concrete assessment tools to use in your daily work.

Who is eligible for HUD-VASH?

The HUD-VASH program targets the most vulnerable, most needy, and chronically homeless Veterans in our country—those who, but for long-term housing assistance and supportive services—would not be able to successfully exit homelessness. It targets those Veterans that are in and out of shelters, emergency rooms, and inpatient mental health treatment programs; and those who have not been able to achieve stable long term housing and, as a result, are unable to fully engage in treatment services or maintain steady, safe housing. Eligibility for HUD-VASH, therefore, avoids the usual preconditions that often prevent chronically homeless Veterans from entering housing programs or obtaining other forms of housing assistance. The only screening criteria that apply to HUD-VASH applicants are outlined below.

Maximum Screening Criteria for HUD-VASH

Homeless Status	Family Status	VA Status	PHA Status
HUD-VASH “screens in” the most vulnerable homeless, many of whom meet HUD’s definition of chronically homeless. All must meet the HUD/McKinney-Vento Act definition of homeless.*	HUD-VASH serves individual Veterans and those with dependent family members.	HUD-VASH does not require treatment. Veterans must have eligible discharge status, be eligible for VA medical services, and be willing to meet regularly with a Case Manager.	HUD-VASH eliminates all PHA screening except for the prohibition on Veterans or family members who are lifetime registered sexual offenders.

* The Federal Definition of Homelessness can be found at <http://portal.hud.gov/hudportal/HUD?src=/topics/homelessness/definition>

The Housing and Services Needs Assessment

To determine which Veterans truly need HUD-VASH and which Veterans would be better served through other housing options, jurisdictions should use a Housing and Services Needs Assessment. This Housing and Services Needs Assessment should be conducted in two parts. First, housing needs and service needs should be evaluated as two separate but interrelated domains. Second, the Veteran's own preferences must be considered.

HOUSING REQUIREMENTS AND SERVICE NEEDS

When assessing housing needs, it will be helpful to consider the following questions. Please note the importance of identifying the number of dependent family members that will be included in the housing unit (see footnote on page 27).

- 1) What is the Veteran's current housing situation (i.e. is the Veteran homeless, precariously housed, doubled up, in own housing but facing housing loss/eviction, or stably housed)?
- 2) What has been the Veteran's history or pattern of housing stability/instability? If the Veteran is currently homeless, how long has the Veteran experienced homelessness? If the Veteran has a history of homelessness, how many times and how recently has the Veteran been homeless?
- 3) What is the Veteran's track record and experience with having an apartment, maintaining a home, and/or paying rent?

When determining what level of service intensity is most appropriate to help the Veteran achieve his or her recovery goals, ask the following:

- 1) Does the Veteran have complex service needs or health conditions (e.g. serious mental illness, substance use disorder) or multiple barriers to independent living? Does the Veteran need service supports connected to housing indefinitely in order to exit homelessness?
- 2) Does the Veteran have non-chronic service needs that, with appropriate treatment or services, could be overcome or managed?
- 3) Does the Veteran have few or minor service needs, but is otherwise able-bodied and employable?

The Housing and Services Needs Assessment can also incorporate a bio-psycho-social approach that evaluates the Veteran's ability to meet tenancy obligations. Standard tenancy obligations that may be important to consider are listed below.

- Payment of rent and utilities
- Allowing other tenants the peaceful enjoyment of their homes
- Maintaining a safe and healthy living environment
- Not engaging in violence or criminal activity
- Allowing only those on the lease to live in the unit
- Complying with all other lease requirements and building rules

It is important for the Veteran and the Case Manager to consider the comprehensive picture of responsibilities and obligations and to explore how these align with the Veteran's treatment and recovery goals. Ensuring that the Veteran tenant remains stably housed is the core of housing stabilization case management work.

Once the Housing and Services Needs Assessment has been completed, use the following chart to determine the most appropriate housing option.

		HOUSING NEEDS			
		Low	Moderate	High	
<p>Targeting Veterans for HUD-VASH vs. other VA programs should involve a consideration of housing needs and service needs as two separate but interrelated domains.</p>		<p>Veteran is currently and stably housed (rents or owns home or resides in with family members), though may have occasional problems paying housing costs</p>	<p>Veteran is currently housed, at imminent risk of housing loss due to eviction, has had history of housing crises/homelessness, or is housed in a temporary setting</p>	<p>Veteran is currently homeless and has had history of housing instability and homelessness</p>	
SERVICE NEEDS	Low	<p>Veteran is able-bodied, connected to workforce, and few barriers to employment, self-sufficiency, and activities of daily living</p>	<p>Standard VA Services/Benefits</p>	<p>Supportive Services for Veteran Families</p>	<p>Supportive Services for Veteran Families</p>
	Moderate	<p>Veteran has some barriers to employment, self-sufficiency, or activities of daily living, which can be overcome or attenuated through services and treatment</p>	<p>VA Treatment Services</p>	<p>Supportive Services for Veteran Families or Grant and Per Diem</p>	<p>Supportive Services for Veteran Families or Grant and Per Diem</p>
	High	<p>Veteran has multiple and complex barriers to employment, self-sufficiency, and activities of daily living, such that services are needed on an ongoing basis</p>	<p>VA Patient-Centered Health Home</p>	<p>HUD-VASH</p>	<p>HUD-VASH</p>

CLIENT PREFERENCES

When matching clients with housing options, it is critical to consider not only what each Veteran needs, but also what he or she *wants*. Explore motivations, preconceived notions, fears, or limitations behind certain preferences (e.g., the Veteran may only be considering one neighborhood because that is the only area where he or she knows the public transportation system). Consider solutions to these problems, or ways that the Case Manager or Peer Support Specialist might help introduce alternatives. However, in the end, when considering the Veteran’s preferences, remember that failure to meet defined bottom-line needs can result in failed housing arrangements.

Some of the key housing features to discuss with the Veteran are

- Location,
- Household composition (including pets)¹,

- Size and type of unit desired,
- Transportation needs,
- Environmental or ADA (or other “reasonable”) accommodations required (e.g., elevator, ramp),
- Safety/security features, especially in cases that involve a history of violence or abuse,
- Proximity to supports/significant other/services/children’s schools, and
- Availability of support “attached” to the housing.

Ask the Veteran to rank his or her top three preferences and explain his or her most important needs to help you understand where the Veteran is willing to compromise and what the “dealbreakers” are.

¹ It is very important that the entire household that will be living with the Veteran be identified at the time of referral to the PHA to assure that an appropriate unit size is identified and because the limitations on PHA screening refer to all members of the family referred to the PHA.

Some people may be hard to engage in the housing conversation, especially those who have been homeless for a long time or have who have had bad experiences with other service providers. Strategies for drawing the Veteran into the discussion include

- engaging in repeated, non-intrusive patterns of interaction;
- respecting boundaries;
- allowing time for trust to develop;
- listening to what the Veteran wants;
- creating space for information to unfold over time;
- assisting the Veteran with plans, services, and resources to meet identified needs;
- clearly explaining how you can be helpful; and
- remaining patient yet persistent.

Is HUD-VASH the right program?

Following screening and the Housing and Needs Assessment, the Veteran's application should be considered in light of the larger objectives of the program. HUD-VASH is intended to rapidly house the most vulnerable Veterans. Given the imminent goal of ending homelessness among Veterans and with nearly 67,495 Veterans experiencing homelessness on a single night in January 2011 (2011 HUDPoint in Time (PIT) count), other housing options besides HUD-VASH are also needed to achieve this goal. These options include

- Homeless Domiciliary Residential Treatment programs (short term treatment; average length of stay is 100 days),
- Grant and Per Diem (transitional housing),
- Supportive Services for Veteran Families (homeless prevention and rapid re-housing), and
- Other VA treatment, health, and employment services and benefits.

Conducting a Comprehensive HUD-VASH Assessment

Once the Case Manager has an understanding of the Veteran's housing and services needs and preferences, the Case Manager will conduct the Comprehensive HUD-VASH Assessment. A completed Comprehensive HUD-VASH Assessment will provide deeper understanding of how the Veteran functions in several key areas that relate to housing stability, identified by practitioners of the Critical Time Intervention (CTI) model, a practice with proven utility for reducing homelessness (www.criticaltime.org).

Stable housing is critical to the achievement of other life goals; if possible, the housing plan should be aligned accordingly. For Veterans who are entering the HUD-VASH program with their families, this discussion often needs to also center around opportunities they'd like to have for their children.

The Comprehensive HUD-VASH Assessment begins with questions aimed at understanding the Veteran's current goals and preferences. As the assessment progresses, it engages the client and his or her family in a discussion of goals, hopes, and aspirations over the next five to ten years. Case Managers should help Veterans consider these questions, develop reasonable plans to further these goals, and reinforce a focus on the future. All too often, people are so busy attending to immediate needs that a connection to longer-term goals and dreams that helps build motivation for change and growth is lost.

Comprehensive HUD-VASH Assessment

Housing and Homelessness History – Last 5 years

Name/Location	Type	Start	End Date	Leaseholder	Reason for Leaving

- Restrictions on location? Y or N Explanation

- Ever evicted from public or subsidized housing? Y or N

- Ever in foster care? Y or N

- Barriers to housing stability? e.g., trouble budgeting, visitors create problems, involved in illegal activity, no experience as lease holder, history of violence

- Housing plan

- Housing goals

- Motivation to obtain/maintain housing

Employment History – Last 5 Years

Employer	Position/Title	Wage	Start	End	Reason for Leaving

- Employment goals

- Currently receiving services?

- Services needed to access or maintain employment

- Motivation to obtain employment

Comprehensive HUD-VASH Assessment

Benefits and Entitlements

Income Receiving	Amt and End Date	Income Source	Amt and End Date
Unemployment Income		General Assistance	
Supplemental Security Income (SSI)		Retirement from Social Security	
Social Security Disability Income (SSDI)		Child Support	
Veteran's Disability Payment		Alimony or other spousal support	
Private Disability Insurance		Unemployment Insurance	
Worker's Compensation		Veteran's Pension	
TANF		Other (list):	
<ul style="list-style-type: none"> Plan to apply for or maintain income benefits 			
Noncash Benefits	Y or N		
Food Stamps	Y or N	TANF Child Care Services	Y or N
Medicaid	Y or N	TANF Transportation Services	Y or N
Medicare	Y or N	Other TANF-funded Services	Y or N
State Children's Health Insurance Pgm	Y or N	WIC	Y or N
Private Health Insurance	Y or N	Other: (list)	Y or N
<ul style="list-style-type: none"> Plan to apply for or maintain noncash benefits 			
<ul style="list-style-type: none"> Barriers to Obtaining/Maintaining Entitlements: 			
Debts			
<ul style="list-style-type: none"> Credit status/score 			
<ul style="list-style-type: none"> Plan to pay off debts 			
<ul style="list-style-type: none"> Barriers to pay off debts 			
<ul style="list-style-type: none"> Services needed – pick list 			
<ul style="list-style-type: none"> Motivation to resolve credit/debt issues 			
<ul style="list-style-type: none"> Goals 			
Legal			
<ul style="list-style-type: none"> Current probation/parole Status 			
<ul style="list-style-type: none"> Name of PO: _____ Date supervision ends _____ 			
<ul style="list-style-type: none"> Felony history last 5 years 			
<ul style="list-style-type: none"> Incarceration history – last 10 years 			
<ul style="list-style-type: none"> Current involvement – e.g., engaging in criminal activity, current legal proceedings, outstanding warrants, subject to order of protection, etc. 			
<ul style="list-style-type: none"> Child support enforcement status 			
<ul style="list-style-type: none"> Services needed 			
<ul style="list-style-type: none"> Motivation to resolve legal issues 			

Comprehensive HUD-VASH Assessment

Education History

- Highest Grade Completed: Some HS HS Diploma or GED Some College Associate's Degree
 Bachelor Degree Technical Certification - Field: _____
 Other
- Current status In school Applying
- Education Goals
- Services Desired

Physical and Behavioral Health (including Trauma-related illnesses)

- Diagnosis: Medical, Mental Health, Substance Abuse, Mental Retardation – Include all axes
- Severity of each illness
- Treatment history for each diagnosis
- Names and contact info for all current service providers - Name, Organization, Phone #
- Describe how health issues impact housing stability
 paying rent disruptive behavior hoarding noise visitors
 Other: _____
- Current medications
- Adherence to medication regimen: Almost Always Sometimes Never
- If substance abuse diagnosis, current status and impact on functioning
 Actively using and not a problem Actively using and a problem Reducing use
 Abstinent: Date of Sobriety mm/dd/yy
- Frequency of Use: Daily Several Times Per Week Once a Week Less than 1X a Week
- Hospitalizations in last 3-5 years: dates, reasons, hospital names
- Detox in last 3 years: number of inpatient detox stays
- Services needed
- Motivation to use services:
- Current stage of change: pre-contemplation, contemplation, preparation, action, or maintenance
- Include narrative explanation

Family/Dependent Children

- Domestic violence/abuse history
- School attendance/performance of children
- Child custody
- Child care arrangements
- Special needs
- Children's services (foster care) Involvement – status, worker name and contact
- Current services providers and contact information
- Services needed
- Motivation to use services

Comprehensive HUD-VASH Assessment

Independent Living Skills/ Supports

- Status of ID for all household members
- Nature of social and familial relationships – identify supports and significant others, also identify negative influences and relationships
- History of seeking and using help/assistance
- Independent Living Skills Score

1 - Mostly Independent 2 - Needs Help Sometimes
3 - Needs Help Most of the Time 4 - Always Needs Assistance

1. Paying bills	1-4
2. Budgeting	1-4
3. Maintaining entitlements and other paper work	1-4
4. Maintaining a home	1-4
5. Preparing/obtaining meals	1-4
6. Travelling	1-4
7. Personal care/hygiene	1-4
8. English proficiency	1-4
9. Awareness of needs and knowing when to seek help	1-4
10. Able to access help when needed	1-4
11. Managing health/behavioral health needs and services, etc.	1-4
12. Taking medications	1-4
13. Keeping appointments	1-4
14. Discriminating danger/asserting and protecting self	1-4
Total score on Independent Living Skills (Range 14-56)	
<ul style="list-style-type: none"> • Ability and motivation to improve skills: 	

Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your knowledge about whether HUD-VASH is the right program for particular types of Veterans.

- 1) Under Fair Housing laws, PHAs must adhere to the same screening criteria for HUD-VASH as they do for all other housing voucher recipients.
- 2) The VA has recently adopted a 10-Year Plan to End Veteran Homelessness.
- 3) Homelessness is defined by the local housing authority.
- 4) If a Veteran has high service needs but low housing needs, the Veteran may be better served by a patient-centered medical home (or health home) than HUD-VASH.
- 5) Understanding tenancy obligations is important for the Case Manager.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) Can you name three Veteran-specific housing programs?
- 2) What are the key housing-related questions to ask when performing a Housing and Services Needs Assessment?
- 3) If a Veteran came to the VA seeking assistance from HUD-VASH because he had just lost his job and was unable to continue paying rent, what responses could you provide?
- 4) What are the key housing features to discuss with a Veteran before searching for an apartment?

All about Vouchers

What's in This Chapter?

The responsibility of the HUD-VASH program, including voucher allocation and geographic distribution, is shared by the U.S. Departments of Housing and Urban Development and Veterans Affairs. Thus, this partnership represents interagency cooperation at the highest level. While the oversight of HUD-VASH is dependent upon an alliance at the federal executive level, the successful operation of HUD-VASH is dependent upon functional relationships at the local level. Additionally, collaboration between individual Veterans Administration Medical Centers (VAMCs) and local Public Housing Authorities (PHAs) is also critical to the success of the program. While VAMCs receive additional staffing for HUD-VASH, PHAs do not. Therefore, VA HUD-VASH team members will need to take on the responsibility of learning to navigate through PHAs—getting to know staff, learning PHA lingo, becoming familiar with PHA practices and rules—in order to best help the Veterans they serve.

In this chapter you will learn

- How the housing subsidy provided in HUD-VASH works, including key functions such as housing inspections, rent calculations, voucher portability, and payment standards;
- How to support HUD-VASH applications with proper documentation; and
- How to manage reasonable accommodations for Veterans with disabilities.

After reading this chapter, you will have working knowledge of PHA rules and requirements, which will enable you to engage your PHA partners and support Veterans in meeting requirements for their housing vouchers.

Introduction to Housing Choice Vouchers

Veterans participating in the HUD-VASH program will receive a long-term housing subsidy through HUD's Housing Choice Voucher Program (HCV). This program is the successor to the 'Section 8' program, and is often called by that prior name.

The HCV program is administered locally by public housing authorities (PHAs). The PHAs are responsible for conducting the intake process for eligible families, verifying income and calculating subsidy amounts, inspecting units to assure that they meet quality standards, and processing subsidy payments to landlords. The PHAs also conduct annual income re-verifications and housing unit re-inspections.

HCVs are primarily used to provide tenant-based rental assistance. HUD provides the difference between an affordable tenant payment (usually 30% of adjusted income) and the cost of decent, standard housing in the community.

VA and the PHA have separate criteria for determining both initial and continuing eligibility. The following chart summarizes the roles and responsibilities as a Veteran goes through the application process and then transitions to long-term housing assistance.

ELIGIBILITY DETERMINATION SUMMARY		
ISSUE	ROLE (Primary Responsibility Indicated by Shaded Area)	
	VA	PHA
Priority of Assistance	Program assignment and assistance priority is determined by VA.	Participating PHAs have no role in determining priority of assistance, homeless status, VA eligibility, or service intensity requirements.
Homeless Status	The VA will evaluate the Veteran's homeless status using the definition of 'homeless' in the McKinney-Vento Act, 42 U.S.C. 11302.	
Health Care Eligibility Determination	The VA determines whether the Veteran is eligible for health care services from the Department of Veterans Affairs.	
Eligibility Based on Service Record and Discharge Status	The VA determines whether the Veteran is eligible based on the nature of the separation from active duty. Requires DD-214.	
Case Management Needs	The VA determines whether the Veteran is willing to participate in case management services provided by the VA. Failure to participate in case management can be grounds for the VA to terminate or deny the Veteran's participation in HUD-VASH. If the VA determines that the Veteran no longer requires case management services, the Veteran can continue to receive the HUD-VASH housing subsidy.	
Income Threshold	HUD-VASH Case Managers should discuss income eligibility requirements prior to application with the PHA. This discussion should include consideration of disability/education/caregiver support benefits, etc., as well as any other subsidies, and should also set realistic goals for budgeting.	The PHAs are responsible for doing the intake process for eligible families, verifying income, and calculating subsidy amounts. PHA may deem the applicant ineligible if the income threshold is exceeded.
Sexual Offender Status	Case Managers should work with the Veteran and his or her family to ensure that these issues are addressed before application to PHA in order to streamline process.	PHA must refuse application if any member of the household is subject to a lifetime registration under a sex offender registration program in any state. If the registered sex offender is a family member other than the eligible Veteran, assistance can be provided if that family member is permanently removed from the household. Neither the Veteran nor any member of his/her household may be listed on any lifetime sexual offender registry.

<p>Accommodation Suitability Determination</p>	<p>Housing search is facilitated by the Case Manager and/or the Peer Support Specialist, keeping HUD occupancy standards in mind. The Case Manager and the Veteran should evaluate potential housing units while considering recovery and treatment goals.</p>	<p>The PHA is responsible for inspecting units to ensure that they meet quality standards. The PHAs also conduct annual income re-verifications and re-inspections of housing units.</p>
<p>Tenancy Obligations</p>	<p>VA Case Managers should be familiar with the obligations of tenancy, be a secondary point of contact for landlords, and help Veteran develop money management skills and pay his/her share of the rent.</p>	<p>The PHA processes subsidy payments to landlords. In order to receive the housing subsidy, the Veteran must abide by the terms of the lease and pay his/her share of the rent. When this does not occur, the PHA determines whether or not the Veteran continues in the Housing Choice Voucher program.</p>
<p>Adding Residents to the Housing Unit</p>	<p>Case Managers should advise Veterans that the standards PHAs use to screen participants for initial application to HUD-VASH are much different than the normal PHA screening criteria. Thus, it is very important to work with the Veteran to identify family members who might eventually plan to live in the housing.</p>	<p>Family members who do not meet the normal PHA screening criteria will not be allowed to join the family later, except in cases of birth, adoption, or court-awarded child custody. Although HUD substantially changed the requirements for program intake, it left intact all provisions that permit PHAs to terminate program beneficiaries.</p>

The VA has primary responsibility for determining eligibility to the HUD-VASH program, which includes

- Determining whether the Veteran’s discharge from the armed forces meets eligibility requirements;
- Determining whether the Veteran is eligible for health care services from the Department of Veterans Affairs;
- Determining whether the Veteran is homeless, according to the definition set forth by the McKinney-Vento Act; and
- Determining whether the Veteran is willing to participate in case management services provided by the VA.

Failure to participate in case management can be grounds for the VA to terminate or deny the Veteran’s participation in HUD-VASH. If the VA determines that the Veteran no longer requires case management services, the Veteran can continue to receive the HUD-VASH housing subsidy. In such cases, the Case Manager should notify the PHA that case management is no longer required by the Veteran but his/her eligibility for a housing voucher remains unchanged. If the PHA has a voucher available in its regular HCV program, the PHA can offer that voucher to the Veteran and open up the HUD-VASH voucher for another homeless Veteran. **Veterans who are being converted from a HUD-VASH Voucher to a traditional Housing Choice Voucher do not have to be placed on a waiting list;** they are already

'participant' in the HCV program and can receive the next available voucher from the PHA.

The VA has sole responsibility for making these determinations. Participating PHAs have no role in determining homeless status or in establishing any priorities for assistance.

Upon initial referral to the PHA for participation in HUD-VASH, the PHA may only deny assistance for two reasons:

- 1) The family exceeds the income threshold, or
- 2) A member of the household is subject to a lifetime registration under a state sex offender registration program. If the registered sex offender is a family member other than the eligible Veteran, assistance can be provided if that family member is permanently removed from the household. Neither the Veteran nor any member of his/her household may be listed on a lifetime sexual offender registry in any state.

In tenant-based rental assistance, the Veteran has the opportunity to choose a housing unit of his or her choice in the community, provided the unit meets the following requirements:

- Units must meet **Housing Quality Standards** (HQS) established by HUD. The unit must be inspected by the PHA initially and on an annual basis thereafter. If a unit does not meet the HQS standards, the landlord can make improvements and request a re-inspection.

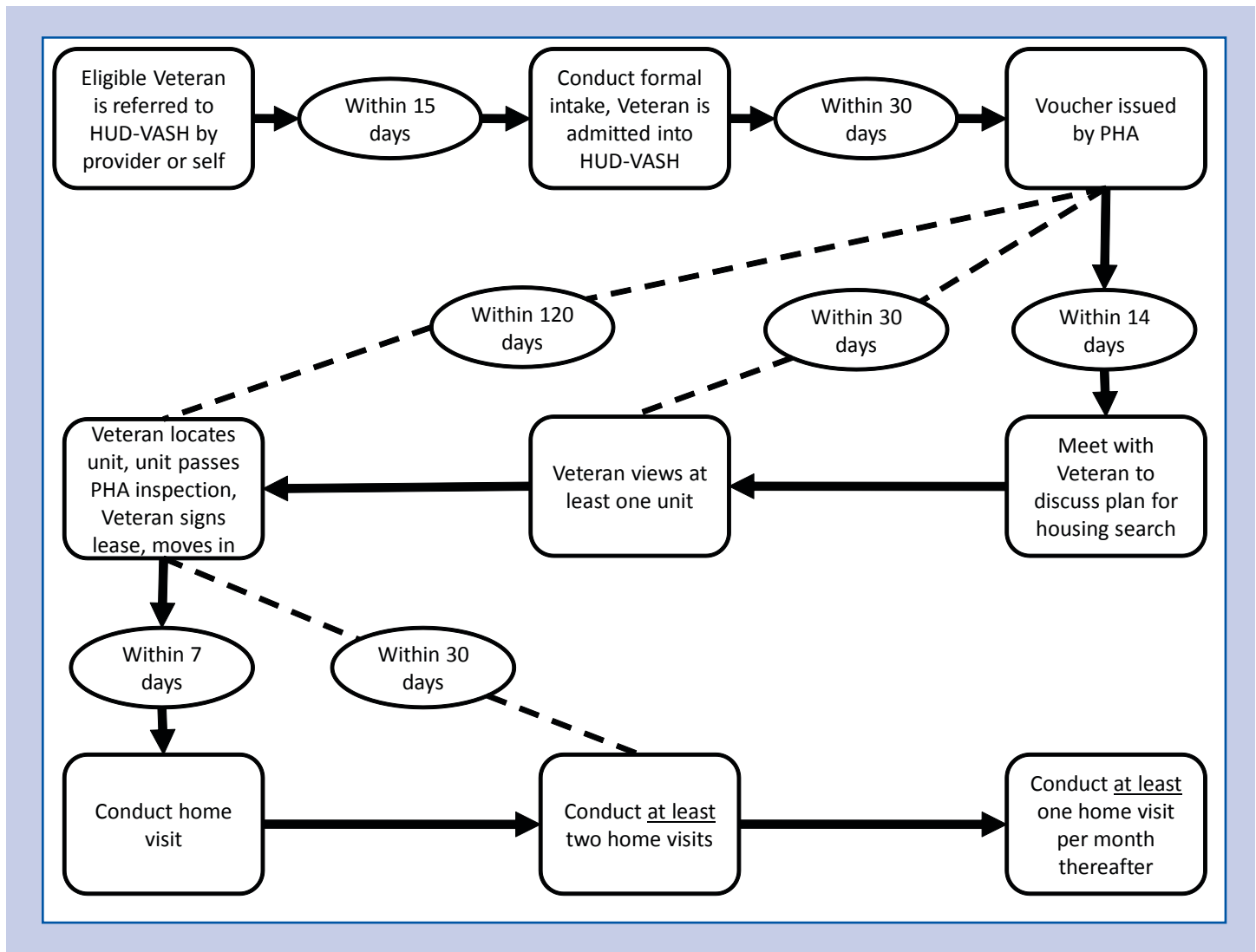
- The rent charged for the unit must be determined by the PHA to be **reasonable**.
- "Reasonable" means that the rent is comparable to that charged for similar non-luxury housing in a similar location with similar amenities.
- The unit must be affordable to the Veteran. Under the HCV program the Veteran will receive a subsidy limited to a 'payment standard' established by the PHA based on HUD's Fair Market Rent guidelines. The housing subsidy can be no greater than the difference between the PHA's Payment Standard and the Veteran's required rent payment (the tenant's rent payment is explained in the following pages).
- The landlord must be willing to rent to the Veteran after whatever screening the landlord normally performs. Additionally, the landlord must be willing to enter into a lease with the Veteran, and this lease must adhere to the terms required by the PHA.

In order to receive the housing subsidy, the Veteran must abide by the terms of the lease and pay his/her share of the rent. Significant and/or repeated lease violations, including failure to make monthly rent payments, can potentially lead to eviction (only permitted upon court order) and termination from the Housing Choice Voucher program by the PHA.

Securing Housing Assistance under HUD-VASH

The flow chart presented below outlines the process for securing housing assistance through the HUD-VASH program. The point of entry is always through the Department of Veterans Affairs; the VA will refer eligible Veterans to the PHA for processing.

Figure 1: HUD-VASH Housing Process



Public Housing Authority Documentation

PHAs are required to obtain verification of information provided by applicants for HCVs.

Identity Verification

The PHA must obtain a Social Security Number (SSN) for all household members. Original documents issued by the VA providing the name and SSN of the Veteran will satisfy the PHA SSN documentation requirement. Acceptable SSN documentation includes

- Original SSN card issued by the Social Security Administration;
- Original SSA-issued document which contains the name and SSN of the individual; **or**
- Original document issued by a federal, state, or local government agency which contains the name and SSN of the individual.

Income Verification

PHAs must next verify the income of the Veteran and the Veteran's family in order to determine whether they meet the income limitations for the program. The income limitation applies only to the initial application to enter the program. HUD has detailed rules regarding which sources of income (both earned and benefit income) must be included when determining income eligibility. HUD-VASH Case Managers should stay abreast of policy changes and alterations to available benefits. For example, as of May 2010, HUD has determined that benefits received under the VA's Incentive Therapy (IT) and Compensated Work Therapy (CWT) programs must be counted as part of the Veteran's income.

HUD-VASH Case Managers can expedite the process of determining and verifying income by PHAs. HUD rules allow PHAs to accept original third party verification of income supplied by applicants for HCVs. To ensure that Veterans experience minimal delays in processing, it is recommended that HUD-VASH Case Managers assist Veterans in assembling

documentation (from third party sources). This will expedite processing by the PHA, which, in turn, will expedite the housing search.

Understanding the Housing Subsidy Provided under HUD-VASH

Veterans enrolled in HUD-VASH receive a Housing Choice Voucher (HCV). Receipt of a HCV requires that Veterans abide by the terms of their lease, including rent, otherwise known as the 'Total Tenant Payment'. In the HCV program the **Total Tenant Payment** is the greatest of

- 10% of the Veteran's family's gross income,
- 30% of the Veteran's family's adjusted income, or
- Welfare assistance grant for housing expenses.

Additionally, PHAs have the option of requiring a minimum rent. The minimum rent would apply when the Total Tenant Payment (calculated above) is less than the minimum rent. For example, if the Veteran had no reportable income and, therefore, no required rental payment, the PHA would charge the minimum rent. The minimum rent may not exceed \$50. Veterans whose inability to pay the rent is based upon a hardship which is likely to be permanent can apply to the PHA for a **hardship exemption** to the minimum rent.

Hardship Requests

PHAs are required to grant exemptions to the minimum rent when the Veteran is unable to pay the rent due to long-term financial hardship. Examples of financial hardship can include

- Risk of eviction because of difficulty paying the minimum rent;
- A decrease in earned income resulting from job loss, reduction in hours, etc.;
- Lag in benefits as Veteran waits for eligibility determination for federal, state, or local assistance programs; or

- A death in the family or other change in household composition accompanied by a reduction in family income.

When a Veteran requests a hardship exemption, the PHA **must**

- Temporarily suspend the minimum rent charge and adjust the subsidy payment for the Veteran. This is effective on the 1st of the month following the change in the Veteran's circumstance.
- Evaluate the hardship exemption and determine whether it is long-term or temporary. The PHA is not required to grant an exemption to the minimum rent if it finds that the hardship is **temporary**. If the PHA finds that the hardship is temporary, the minimum rent is reinstated retroactively to the date of suspension. The PHA must offer a reasonable repayment agreement for the minimum rent charges accumulated during the suspension.

Maximum Subsidy in the HCV Program

HUD will never provide a subsidy greater than the difference between the payment standard for a unit of appropriate size for the Veteran's family and the total tenant payment paid by the Veteran. HUD establishes a Fair Market Rent (FMR) schedule for all metropolitan and non-metropolitan areas in the country. This is considered to be the cost of standard, non-luxury housing (including necessary utilities) in the community. Each PHA is allowed to establish a payment standard between 90% and 110% of the FMRs in the community.

While a lower payment standard will allow the PHA to subsidize more units in the community, it may, however, also make it more difficult for program participants to find suitable housing. A higher payment standard will make more units available for the program, but it may also result in fewer families being served through the program.

The maximum subsidy is the difference between the payment standard for the appropriate unit size (or the unit size actually rented – if the unit is smaller than the participant would have been eligible for) and the Total Tenant Payment by the Veteran.

Income Adjustments in the HCV Program

HUD allows 5 deductions to gross income. It is important that Veterans access all the income adjustments to which they are entitled. These adjustments will, in most cases, reduce the Total Tenant Payment and, therefore, decrease the amount of money the Veteran has to pay 'out of pocket' to cover his or her housing costs. Two of the adjustments apply to all households in the HCV program; three are limited to households headed by persons with disabilities. These adjustments are as follows:

- All households are eligible for a **dependent deduction** of \$480 per year per dependent. Dependents are persons under 18 years of age or full time students. Foster children are not considered dependents and neither the household head nor co-head can qualify as a dependent. Each dependent in the household qualifies for the \$480 per year deduction.
- Households are allowed to deduct '**reasonable childcare expenses**'. Childcare is provided for when it is necessary to allow an eligible household member to work or to attend an educational program focused on increasing job skills/employability. By 'reasonable,' HUD means that the costs should not exceed those incurred by typical households for child care. The deduction for childcare cannot exceed the earnings through employment of the household member taking the deduction.
- Households headed by an **elderly or disabled person** are entitled to an annual income deduction of \$400. Only **one** deduction of \$400 is permitted for each eligible household.

The Housing Choice Voucher Program Guidebook (<http://www.hud.gov/offices/adm/hudclips/guidebooks/7420.10G/>) provides a step by step guide to documentation requirements for verifying income, assets and deductions from income at the end of Chapter 5. Case Managers should review the requirements and assist Veterans in assembling the materials required by the PHAs.

Elderly is defined as 62 and over; if the Veteran is disabled according to HUD's definition, the household is also eligible for the deduction.

- Elderly or Disabled households are allowed to deduct '**excess medical expenses.**' These are expenses that are in excess of 3% of their annual gross income. Although the household must be elderly or disabled to qualify for this deduction, all **medical expenses** of all household members are considered.

Medical expenses include

- services of a physician or other health care professional,
- services of a hospital or health care facility,
- medical insurance premiums (including payments under Medicare),
- prescription and non-prescription medications,
- dental expenses,
- eyeglasses and eye examinations,
- live-in or periodic medical care assistance (visiting nurses or care attendants),
- medical or health products or apparatus, and
- periodic payments on medical bills.
- **Disability expenses** can be deducted to the extent that they exceed 3% of annual income. This deduction is intended to permit the disabled person or other family member to work. Therefore, this deduction cannot exceed the amount of income generated by the family member who is working. Disability expenses cannot include any expense reimbursed through insurance or any other source. Disability expenses, for example, often include cost of a care attendant or auxiliary apparatus that enables a household member, and the disabled member, to work.
- When a household qualifies for **both medical and disability expense deductions**, the allowable deduction amount is the amount by which the **combined expenses** exceed 3% of annual income.

Many of the allowable deductions for childcare, medical expenses, and disability expenses will apply

to homeless Veterans receiving assistance through HUD-VASH. These deductions can substantially decrease the amount of money the Veteran will have to expend each month for housing. It is important that Case Managers review the deductions, determine whether the Veteran qualifies for any of the deductions, and assist the Veteran in obtaining third party documentation. PHAs are only required to accept as deductions expenses that are fully documented by third party sources.

Housing Persons with Disabilities

In addition to deductions in income for the calculation of tenant contribution to housing costs, Veterans with disabilities are eligible for additional kinds of assistance in the HCV program. This includes the right to have the services of a 'live-in aide', the right to request reasonable accommodations in order to participate in the program, and eligibility for the earned income disregard benefit. As HUD-VASH targets Veterans who often have severe mental, physical, and/or substance use disorders, many of these Veterans will be considered disabled by HUD. IF HUD determines that the applicant is disabled, he or she may need to use the special allowances for persons with disabilities in order to participate in the HCV program.

Defining "Disability" for the HCV Program

- PHAs are likely to follow the 'letter of the law' in terms of determining whether a Veteran is disabled for the purposes of the HCV program. Therefore, this section details the definition of a person with disabilities according to HUD program regulations.

Definitions for the Housing Choice Voucher program are found in the federal regulations at 24 CFR 5.403, "Definitions." The definition of a 'person with disabilities' means a person who

- 1) Has a disability, as defined in the Social Security regulations (42 U.S.C. 423), as an "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment

which can be expected to result in death, or which has lasted, or can be expected to last, for a continuous period of not less than 12 months”; or

- 2) Is determined to have a physical, mental, or emotional impairment that
 - (A) Is expected to be of long-continued and indefinite duration,
 - (B) Substantially impedes ability to live independently,
 - (C) Is of such a nature that the ability to live independently could be improved by more suitable housing conditions, or
- 3) Has a developmental disability, as defined in federal regulations, 42 U.S.C. 6001, that is severe, chronic, persistent after early childhood, likely to continue indefinitely, and which results in functional limitations in multiple areas of major life activities.

When the Social Security Agency (SSA) disability determination applies, it includes anyone who receives Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Individuals with this designation automatically receive a disability determination in the HCV program. When the second case applies, a state licensed clinician must provide signed certification that a Veteran has a physical, mental, or emotional impairment that meets the three criteria above—duration, severity of impact on independent living, and the potential for substantial increase in function with improvements in housing situation.

The definition of disabilities for the Housing Choice Voucher program also goes on to state that it:

- 1) *“Does not exclude persons who have the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome;*
- 2) *For purposes of qualifying for low-income housing, does not include a person whose disability is based solely on any drug or alcohol dependence; and*
- 3) *Uses 24 CFR 8.3 to define **individual with handicaps** as any person with a physical or*

mental impairment that substantially limits one or more major life activities. For purposes of reasonable accommodations and program accessibility, “major life activities” means functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

Persons with disabilities are entitled to additional benefits to assist in accessing housing through the HCV program and, under certain circumstances, are eligible for a special incentive for increasing their income through employment. Please see the section below on serving veterans with disabilities through HUD-VASH.

Live-in Aides

Many Veterans with disabilities will require the services of a live-in aide in order to live independently in the community. HUD defines ‘**live-in aide**’ (24 CFR 5.403) as *“a person who resides with persons with disabilities and who is (1) determined to be essential to the care and well-being of the persons; (2) is not obligated to support the persons; and (3) would not be living in the unit except to provide the necessary supportive services.”*

Family members can be classified as ‘live-in aides’ provided they meet the requirements of the definition. For example, the spouse of a Veteran is not likely to meet the definition of a ‘live-in aide,’ because he or she would generally be obligated to support the Veteran, and would be living in the unit regardless of the need to provide necessary supportive services. However, a parent would not be considered obligated to support the Veteran, and, in that case, might not be living in the unit were it not for the need to provide supportive services. A parent in those circumstances would meet the definition of a ‘live-in aide.’ The income of individuals meeting the definition of ‘live-in aide’ is not counted when determining household income and calculating subsidy benefits under HCV. Additionally, the PHA must subsidize a unit with sufficient bedrooms so that, at a minimum, the Veteran and the live-in aide are able to occupy separate bedrooms. It is important, however, to note that changes in VA caregiver assistance laws and updates to caregiver support programs may result in alterations to these

criteria. Spouses and other family members may now be eligible for caregiver assistance benefits, and this should be considered in light of these regulations.

Special Program Provisions for Disabled Persons

There are two very important program provisions that assist people with disabilities in the HCV program:

- The 'Earned Income Disregard,' providing incentives for persons with disabilities to obtain employment income; and
- 'Reasonable Accommodations,' allowing special provisions for people with disabilities in order to obtain equal access to federal assistance programs.

Earned Income Disallowance for Persons with Disabilities

Because the HCV subsidy decreases as income increases, Earned Income Disallowance for Persons with Disabilities was created to abolish the disincentive to increase income by working. Earned Income Disallowance allows persons with disabilities the opportunity to have a steady level of subsidy during the initial period following their return to employment.

In order to be eligible for this benefit, the Veteran must be a person with a disability. Additionally, the Veteran's increase in income must be a result of employment – additional income from benefits *does not* qualify for the benefit. Finally, the increase in income must fit into one of the following categories:

- An increase in income for a person with a disability who had been unemployed for a year or more prior to current employment; or
- An increase in income as a result of participation in an economic self-sufficiency or other job training program; or
- An increase in income due to employment during or within 6 months of receiving benefits from Temporary Assistance to Needy Families (TANF).

When those conditions are met, the following benefits may apply.

- For a period of 12 months, starting with the increase in income resulting from employment, 100% of the additional earned income is disregarded for HCV benefit calculation. Therefore, the housing subsidy is not reduced as a result of the increase in employment income for a full year.
- Starting at the one year anniversary of increased income due to employment, and for the next 12 months, only 50% of the additional income earned from employment is considered in HCV benefit calculation.
- The benefit starts at the time of employment, and not when the PHA does the income recertification.
- Should there be an interruption in the period of employment the benefit is suspended until earned income again increases. However, there is a 48 month time limit on the benefit. Once a Veteran begins to obtain this benefit, all eligibility for the benefit will expire after 4 years. Therefore, if the 48 month period elapses without the Veteran exhausting the 12 month 100% disregard or the second 12 months of 50% disregard, he or she will lose eligibility for the balance of the benefit.

Reasonable Accommodations for Persons with Disabilities

Section 504 of the Rehabilitation Act of 1973 (as amended) prohibits discrimination under any program or activity receiving federal financial assistance solely on the basis of a disability. The rule requires that recipients of federal funds (PHAs in this instance) ensure that individuals with disability receive an equal opportunity to participate in programs and services in the most integrated setting.

Reasonable accommodation: A "reasonable accommodation" is a change, adaptation or modification to a policy, program, service, or workplace that will allow a qualified person with a disability to participate fully in a program, take advantage of a service, or perform a job.

Reasonable accommodations may include, for example, those which are necessary in order for the person with a disability to use and enjoy a dwelling, including public and common use spaces. Since persons with disabilities may have special needs due to their disabilities, in some cases, simply treating them exactly the same as others may not ensure that they have an equal opportunity to use and enjoy a dwelling.

Definition of “individual with disabilities” under Section 504: any person who has physical or mental impairments that substantially limits one or more major life activities has a record of having such impairments, or is regarded as having such impairments. According to the PHA Guidebook, the list of impairments is long and includes learning disabilities, diabetes, alcoholism, emotional illness, cancer, heart disease, AIDS, etc. It does *not* include current, illegal use of or addiction to a controlled substance.

Limitations on reasonable accommodations: PHAs are not required to take any actions which would result in a fundamental alteration in the nature of the program or undue financial or administrative burden. PHAs are, however, required to provide any accommodation that would not result in an undue financial or administrative burden or that would not create a fundamental alteration of the assistance program.

Examples of Reasonable Accommodations for Disabled Veterans in HUD-VASH

Application Process

- Additional time to supply information to the PHA
- PHA briefing on the Housing Choice Voucher Program provided in accessible format or location
- Accepting a household whose members might not meet the PHAs definition of a ‘family’ if the additional person(s) are important to the care and well-being of a person with disabilities

Housing Search

- Additional time for the housing search (beyond the minimum 120 day initial term)
- A higher payment standard (for an accessible unit or a unit located near transportation needed to access services). The PHA can approve up to 110% of the Fair Market Rent; the HUD Field Office can approve requests for rents between 110 and 120% of the Fair Market Rents.
- Permission to rent from immediate family members – however, a reasonable accommodation cannot be requested to lease from a family member who will also be residing in the same housing unit.
- Permission to rent ‘types’ of housing such as congregate housing or manufactured housing that is not otherwise permitted under the PHA Plan – this can include rental assistance for manufactured housing unit that is owned by the Veteran.
- A larger unit in order to accommodate a live-in aide¹

Leasing Process

- Service animals being permitted to reside in the unit even if there is a ‘no pets’ policy
- Reasonable modifications to an apartment needed to obtain full enjoyment of a dwelling
- Assigned parking spaces for people with disabilities; requesting assistance or modifications to procedures around the disposal of refuse to assist a person with disabilities

Relationship Between Reasonable Accommodation and Disability:

In order to show that a requested accommodation may be necessary, there must be an identifiable relationship, between the requested accommodation and the individual’s disability.

¹ PHAs are required to consider a person to be a live-in aide if: (1) the person is determined by the PHA to be essential to the care and well-being of a Veteran who is disabled; (2) the live-in aide is not obligated to support the Veteran; and (3) the live-in aide would not be living in the unit expect to provide the supportive services.

PHA Verification:

PHAs may verify a Veteran's disability only to the extent necessary to ensure that applicants are qualified to reside in the housing for which they are applying and that applicants who have requested a reasonable accommodation have a need for the requested accommodation. A PHA may require documentation of the manifestation of the disability that causes a need for a specific accommodation.

A PHA may not

- Require applicants to provide access to confidential medical records, or
- Inquire into the specific nature of the disability.

Although there is no requirement that reasonable accommodations requests be made in writing, it is generally preferable to maintain a written record. Requests to PHAs for reasonable accommodations should include the following:

- Statement that the request is being made because the Veteran has a disability;
- Explanation of the type of accommodation that is being requested (e.g., an increase in the payment standard, a larger unit to accommodate a live-in aide, etc.);
- Explanation of the relationship between the accommodation requested and the Veteran's disability.

The rights of persons with disabilities to obtain equal access to HUD benefit programs are enforced by HUD's Office of Fair Housing and Equal Opportunity. Veterans who appear to be experiencing discrimination in housing because of disability or any other proscribed reasons may obtain assistance from Fair Housing Agencies. These agencies can be located through an on-line searchable database found at <http://www.fairhousing.com/index.cfm?method=agency.search>.

Termination from the Housing Choice Voucher Program

In implementing the HUD-VASH program, HUD sought to eliminate the barriers to housing homeless

Veterans that could result from the application of the screening and local priorities that accompany the regular HCV program. As a consequence, HUD only permits PHAs – at program intake – to screen out Veterans whose incomes are too high or when listed on lifetime sexual offender registries.

Although HUD substantially changed the requirements for program intake, it left intact all provisions that permit PHAs to terminate program beneficiaries. It is extremely important that HUD-VASH Case Managers work with Veterans to ensure that they understand all obligations of tenancy. These obligations include occupying the unit for the term of the lease, making monthly rent payments, not interfering with other residents' 'quiet enjoyment' of their housing, not causing damage to the property, not engaging in criminal activity, and not committing violations of federal, state or local laws that directly relate to occupancy of the housing.

HCV is a lease-based program and landlords may only evict a resident through an appropriate court-ordered action. The PHA must be provided a copy of any eviction notice. The PHA can terminate assistance when a Veteran has been evicted from a unit or when there are serious and repeated lease violations.

However, prior to terminating any HCV participant, PHAs must provide the opportunity for an 'informal review or hearing.' PHAs have two hearing processes:

- Informal reviews which permit applicants to request reviews of decisions made by PHAs, and
- Informal hearings which permit participants in HCV to appeal decisions regarding their benefits or their termination from the program.

PHAs must provide notice to Veterans of their right to informal reviews or hearings. This notice must be made in writing and must include

- Statement of reasons for the decision,
- Statement that the Veteran can request an informal review/hearing if not in agreement with the PHA decision, and
- Deadline for requesting an informal review/hearing.

The process by which the PHA will conduct an informal review/hearing is specified in the PHA plan. HUD requires the following:

- The informal hearing cannot be conducted by the person who made the decision under review or a subordinate of that person;
- The Veteran must be given the opportunity to present written or oral objections to the decision;
- The PHA must promptly notify the Veteran of its final decision after the informal review, including a written statement of the reasons for the final decision.

The Veteran is entitled to representation (legal or otherwise), but the PHA is not responsible for paying for this representation. In making its decision under the informal review/hearing, the PHA must consider 'mitigating circumstances related to the disability of a family member.' Any decision by the PHA is subject to consideration of reasonable accommodations. Should the Veteran be terminated as a result of alcohol or substance use, the PHA may require evidence of participation in a rehabilitation

program as a condition for receiving continued HCV assistance. VA Case Managers can appear at these hearings as representatives for the Veterans.

Establishing Positive Working Relations with Public Housing Authorities

PHAs across the country have been highly supportive in the implementation of the HUD-VASH program and supporting the goal of ending homelessness among Veterans. As the program expands, additional PHAs are becoming involved. It should be noted that while the VA has additional staff resources to address the needs of homeless Veterans, PHAs have not experienced similar increases in staffing. Accordingly, it is recommended that HUD-VASH Case Managers take affirmative steps to facilitate Veterans in accessing the HCV program and in maintaining occupancy. In short, do as much work to support the PHA as possible. Case Managers can assemble eligibility and verification documentation to relieve the burden on PHA staff.

STEPS TO ESTABLISH SUCCESSFUL RELATIONSHIPS WITH PUBLIC HOUSING AUTHORITIES

STEP	BENEFIT
Have a kick-off meeting between the VA and PHA whenever a new PHA enters the HUD-VASH program.	<p>Opportunity to establish shared knowledge of:</p> <ul style="list-style-type: none"> ▪ PHA requirements ▪ Process for issuing a voucher ▪ Process for submitting a request for tenancy approval (RTA) ▪ HQS inspection requirements
Encourage the PHA to designate a single staff member to handle HUD-VASH program	Opportunity to maximize coordination and optimize outcomes
Become familiar with HUD's housing quality standards (HQS) to ensure that when request for tenancy approvals are submitted, the units will be approved.	<p>Opportunity to streamline process:</p> <ul style="list-style-type: none"> ▪ VA Case Manager or peer worker can assist the Veteran in identifying units that are not likely to pass inspection, thereby avoiding unnecessary inspections.
Maintain regular contact with PHA counterparts. This could include a bi-weekly or monthly meeting or weekly conference call between the PHA and VA.	<p>Opportunity to maintain open lines of communication:</p> <ul style="list-style-type: none"> ▪ Review cases with outstanding vouchers ▪ Troubleshoot when Veterans under lease are experiencing problems. ▪ Provide a regular forum to address any issues regarding PHA policies or VA needs.
Designate the VA Case Manager as second party to be contacted by the PHA.	<ul style="list-style-type: none"> ▪ Ensures that all communication between the PHA and the VA will be shared with the Case Manager. ▪ In the event that the PHA needs to take any action, the Case Manager will know in advance and can assist in resolving any problems.

REMEMBER: Non-encrypted, client-specific emails cannot be exchanged between the VA and the PHA. However, some PHAs have established shared drive arrangements where a master log of all HUD-VASH clients is maintained, providing the current status of the HUD-VASH application. In other cases, all applications should be reviewed by the PHA/VA in a weekly coordination call.

Understanding the Public Housing Authority Administrative Plan

HUD requires that PHAs adopt written Administrative Plans that set forth local policies for program administration. The plans must conform to HUD regulations and identify the PHA's policies in areas in which HUD allows the PHAs discretion to set local policy. HUD also requires that the plans be consistent with the local jurisdiction's Consolidated Plan, which sets forth general policies and plans for affordable housing and community development.

There are a number of items in the PHA plan that could affect access to HCV by homeless Veterans.

However, it should be noted that, in virtually all cases when a Veteran is a person with disabilities, a reasonable accommodation can be requested that would supersede the requirements of the plan. For example, PHAs are required to adopt a definition of what group of persons would qualify as a 'family.' If the Veteran is disabled and there is a person(s) deemed important to the Veteran's care and well-being, and documented by a medical provider, then the PHA, as a reasonable accommodation, would allow the Veteran and the other person(s) to constitute a family.

PHA REGULATIONS	
PHA PLAN REQUIREMENTS THAT CAN AFFECT HOMELESS VETERANS	
<ul style="list-style-type: none"> ▪ Family definition: PHAs must adopt a definition to describe what groups of persons may qualify as a 'family.' 	
<ul style="list-style-type: none"> ▪ Subsidy standards: PHAs must establish subsidy standards for determining the number of bedrooms needed for families of different sizes and compositions. 	
<ul style="list-style-type: none"> ▪ Absence from unit: Families may be absent from their units for brief periods and continue to receive rental assistance. The PHAs administrative plan establishes how long the family may be absent from the unit before assistance is terminated. The PHA may set its policy for any length of absence up to the maximum of 180 days permitted by HUD. Absence means that no member of the family shown on the lease is residing in the unit. If the PHA sets the time period at less than 180 days, a reasonable accommodation can be requested for up to the 180-day maximum. 	
<ul style="list-style-type: none"> ▪ Payment standards: PHAs may set payment standards from 90% to 110% of the published Fair Market Rent (FMR) for each unit size. Note that a higher payment standard may be requested as a reasonable accommodation. 	
<ul style="list-style-type: none"> ▪ Policies on the use of special housing types: 'Special housing types' include homeownership, single room occupancy, congregate housing, shared housing, group homes, cooperative housing, and space rentals for manufactured housing owned by the family. HUD requires that PHAs allow special housing types if needed as a reasonable accommodation. 	
<ul style="list-style-type: none"> ▪ Minimum rents: PHAs may set a minimum rent, which HUD allows to range from \$0 to \$50/month. PHAs must also establish the process for requesting and granting hardship exemptions to the minimum rents. 	
PHA PLAN ACTIONS THAT CAN ASSIST HOMELESS VETERANS	
<ul style="list-style-type: none"> ▪ Classify disabled homeless Veterans as constituting an 'essential local housing need': Generally speaking, the HCV program is targeted toward very low income families (under 50% of Area Median Income (AMI)) or extremely low income families (under 30% of AMI). However, in the administrative plan, PHAs may adopt a local policy of serving additional low income families (under 80% of AMI) to address essential local housing needs. Some Veterans receiving full service-connected disability payments will have incomes that are above the very low income (50% AMI) level, but below the low income (80% AMI) level. PHAs could determine that disabled Veterans constitute an essential local housing need; allowing Veterans to enter the program under the 'low income' category would allow fully disabled Veterans to be served through HUD-VASH. 	
<ul style="list-style-type: none"> ▪ Accept form DD-214 as verification: Veterans occasionally experience delays in obtaining a voucher because of missing documentation for Social Security numbers and birth certificates. This prolongs the period of time the Veteran remains homeless. 	

Portability of HUD-VASH Vouchers

Another key element of choice in the Housing Choice Voucher program is ‘portability.’ Under the regular HCV program, any eligible family that has been issued a voucher may use it to lease a unit anywhere in the United States where there is a PHA operating a HCV program. This portability provision continues in the HUD-VASH program, but since HUD-VASH requires the participation of both a PHA and a VAMC, there are some differences between portability in HUD-VASH and the regular HCV program.

Veterans are able to move their HUD-VASH voucher—provided that they remain within the jurisdiction of a VAMC that has the reasonable capacity to provide case management. There are two different portability scenarios in the HUD-VASH program.

Scenario 1: Moving within the jurisdiction of the servicing VAMC

Eligible Veterans may live anywhere within the jurisdiction of the servicing VAMC. They are not required to locate a unit within the jurisdiction of the issuing PHA. If they elect to move to a unit that is within the jurisdiction of the VAMC, but outside of the issuing PHA’s jurisdiction, they can move their voucher to that new location. The PHA into whose jurisdiction the Veteran is moving will administer the voucher and bill the issuing PHA for the costs of providing the housing voucher. The Veteran must, however, locate in an area that is within a reasonable distance from the VAMC so that case management services can be effectively provided.

In this scenario, the actual subsidy received by the Veteran will be based on the payment standard in effect at the PHA in whose jurisdiction the housing unit is located. Additionally, if the Veteran is a voucher holder, but has not executed a lease on a HCV-assisted unit, his/her family will have to meet the income standard in the jurisdiction in which the unit is located. If the Veteran’s household is already under lease in a HCV supported unit, income limits no longer apply.

There is no requirement to live for one year in any given location. If the Veteran is under

lease, however, he/she can only move upon the completion of the lease term or if the landlord agrees to terminate the lease.

Scenario 2: Long distance moves – outside of the jurisdiction of the VAMC

Veterans can move their vouchers to new jurisdictions. However, if they are moving outside of the jurisdiction of the issuing VAMC, the VAMC in the jurisdiction to which they plan to move must have available case management and a HUD-VASH voucher slot. This can be confirmed by the VA. If the VA has the capacity to provide case management at the new location, the Veteran can relocate to that jurisdiction and enroll in that HUD-VASH program. As in Scenario 1, the subsidy level will be based on the payment standard at the PHA in whose jurisdiction the housing unit is located. Also, if the Veteran is not yet under lease in the original jurisdiction, the income limits in the new PHA will be used to determine if the Veteran is income-eligible for the program.

Key Practices

- Assist Veterans in assembling third party documentation concerning PHA eligibility requirements, income, and any income deductions for which the Veteran may qualify.
- Determine whether each Veteran needs and qualifies for any of the special provisions for disabled persons and, if so, assist the Veteran in assembling required documentation and requesting appropriate accommodations.
- Train VA case managers in HUD’s Housing Quality Standards (HQS) to avoid unnecessary inspections.
- Establish positive relations with PHAs through:
 - Kickoff meetings with new PHAs,
 - Regularly scheduled meetings and/or conference calls with PHA counterparts,
 - Consistent designations of VA Case Managers as second party to be contacted by PHA, and
 - Establishing processes with the PHA for coordinating review of HUD-VASH applications.

Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your knowledge about HUD-VASH housing vouchers.

- 1) HQS stands for Housing Quality Survey.
- 2) Payment Standards limit the amount of rent a landlord can charge.
- 3) PHA screening for HUD-VASH may include criminal history for drug use.
- 4) Original documents issued by the VA providing the name and social security number of the Veteran will satisfy the PHA’s social security number documentation requirement.
- 5) To reduce delays in processing, PHAs will assist Veterans in assembling documentation (from third party sources) that demonstrates income.
- 6) PHAs may require payment of a minimum rent even if a Veteran has no income.
- 7) HUD uses the Social Security Administration’s definition of disability.
- 8) Portability is the ability of someone with a voucher to move into a different housing authority jurisdiction and still receive subsidy.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) Apartments must pass PHA inspection prior to lease-up. How frequently must they be inspected thereafter?
- 2) What are the five types of deductions to gross income HUD allows?
- 3) What is an example of a “reasonable accommodation” for a Veteran with a disability?
- 4) What is one action a PHA must take regarding informal hearings?
- 5) How can your VA team establish a successful relationship with your local public housing authority?

Case Management—The Key to HUD-VASH Success

What's in This Chapter?

A sustainable exit from homelessness is unlikely without case management. Without the Case Manager, affordable housing cannot be connected to clinical services. While the Case Manager serves in a practical capacity to encourage housing stability and troubleshoot some of the factors that may threaten it, the Case Manager also plays a larger role for the Veteran, as the person who offers meaningful assistance when needed.

In this chapter, you will learn

- What case management means and encompasses in the context of the HUD-VASH program;
- How HUD-VASH case management draws on the successes of both the Critical Time Intervention and Housing First approaches; and
- How case management changes through the different phases of the housing stabilization process.

After reading this chapter, you should understand the role of case management through the lens of housing stabilization and how to employ proven practices for a successful case management approach.

Housing Stabilization Services using Critical Time Intervention (CTI) and Housing First

The HUD-VASH Case Management approach is informed by both evidence-based housing practices and evidence-based counseling techniques. However, it differs from other services in that the

work is focused on housing stabilization—as the primary goal of HUD-VASH Case Management is to help eligible Veterans, and their dependents when applicable, obtain and maintain permanent housing. Thus, the role of the HUD-VASH Case Manager is fundamentally organized around housing access and sustained recovery tasks that include access, engagement in treatment and other supportive services, as clinically indicated.

Case Managers begin the process of housing stabilization by engaging the Veteran in a discussion of his/her housing needs and living preferences, simultaneously exploring the Veteran's goals, strengths and limitations. As the Housing Assessment is being completed, the HUD-VASH Case Manager begins to consider potential service opportunities, resource allocations, and possible obstacles to housing stability. The resulting Housing Stabilization Plan is based on the combination of this information (see Appendix A). The Case Manager uses the Housing Needs Assessment and the Housing Stabilization Plan to shepherd the Veteran through the administrative process of securing housing.

During this and all other phases of housing stabilization, HUD-VASH Case Managers consistently monitor for problems that can jeopardize tenancy. Thus, the Housing Stabilization Plan should be updated regularly, incorporating the Veteran's needs and goals while also establishing connections between goal achievement and corresponding recovery supports. This approach to case management incorporates principles and practices from two proven housing practices, Critical Time Intervention (CTI) and Housing First, while using the Stages of Change paradigm and Motivational Interviewing techniques.

Critical Time Intervention (CTI) Overview¹

CTI is a proven practice that assists housing stabilization by strengthening a client's long-term ties to community services and social supports such as family and friends. The case management approach is housing-focused and connected to the client's life goals. CTI is broadly applicable—it has been implemented for single adults as well as for families with children; it has also been used with clients transitioning to community-based housing from a variety of homeless and institutional settings.

Core principles and practices of CTI:

- **Focused assessments:** Within HUD-VASH, the Case Manager addresses one to three priority areas, identified from six treatment areas. The priorities are determined by urgency and severity of threat to long-term housing stability, and are addressed in a manner that ensures access to care and support. The six primary treatment areas include housing, health/mental health, substance use, life skills, financial management, and family intervention.
- **CTI is meant to be time-limited:** Although duration of CTI can vary depending on the needs of the client, transition to other community supports is typically provided for nine months.
- **Phased Services:** CTI is organized into three 3-month phases of **decreasing intensity**: 1) Transition to the community, 2) Try out, and 3) Termination/Transfer of care.
- **Connections to mainstream resources and supports:** In order to decrease service intensity, CTI requires that strong connections be established between the service recipient and community-based resources that will continue to address his or her ongoing needs.

From CTI, HUD-VASH case management adopts focused assessments and case management planning that directs priorities toward housing-related needs. CTI's focus on connections with community-based resources and supports is also central to HUD-VASH case management. Additional information on CTI can be found at www.criticaltime.org.

Housing First Overview²

Housing First is another proven approach that maintains an immediate and primary focus on helping homeless people quickly access and then sustain permanent housing. As opposed to programs that work with clients only before they are housed, to help them to become 'housing ready', the Housing First approach helps clients find housing and then provides services for as long as necessary to ensure residential stability. Services are provided in the home, at agency offices, and, when necessary, in the community. Housing First programs can be single-site or scatter-site. Many permanent supportive housing programs have adopted the Housing First approach.

Housing First programs share critical elements:

- Rapid access to housing
- Low or no thresholds for acceptance
- Housing stabilization and improved well-being as the primary goals of services
- Services are focused on helping clients meet lease obligations and changing the behaviors that create tenancy problems
- Substance use is addressed through a harm reduction approach where the focus on engagement and promoting safety
- Housing is not contingent on compliance with services – instead, participants must comply with a standard lease agreement and are provided with the services and supports that are necessary to help them become successful

Using the Housing First framework, HUD-VASH case management incorporates a rapid housing approach with low threshold eligibility requirements. For example, HUD-VASH does not require a set period of sobriety in order for a Veteran to be considered eligible for the program. Veterans with active substance use disorders, or a history of substance abuse, are considered for the program.³ The only

¹For more detailed information on CTI, visit www.criticaltime.org

²For more detailed information on Housing First, go to the <http://www.nrepp.samhsa.gov/>

³Department of Veterans Affairs, 2009. VHA Handbook 1162.05. HUD-VASH Program. Washington, DC, 2.

other threshold criteria for HUD-VASH concerns income requirements, sex offender status, and willingness to participate in case management. Similar to Housing First, HUD-VASH is focused on housing retention and improved well-being.

The following chart illustrates the major tenets of each model of care. Shaded areas represent significant incorporation into the HUD-VASH case management philosophy.

HUD-VASH Case Management Incorporates Principles from Proven Models of Care		
<i>SHADED AREAS REPRESENT THOSE PRACTICES THAT HAVE BEEN INCORPORATED MOST SIGNIFICANTLY INTO HUD-VASH CASE MANAGEMENT</i>		
	CTI	Housing First
GOAL	Assist housing stability by strengthening long-term ties to community services, family, and friends	Housing stabilization and improved well-being
ELIGIBILITY CRITERIA	Willingness to participate in case management	Low or no threshold for services
SERVICE FOCUS	Using ongoing needs assessments, address 1-3 areas at a time, determined by urgency of threat to long-term housing stability	House rapidly; help clients meet lease obligations and change behaviors that create tenancy problems or housing barriers.
TIMING AND/OR DURATION OF SERVICES	Case management is time-limited	Case management lasts as long as necessary to facilitate rapid placement in permanent housing and to sustain long-term housing
CASE MANAGEMENT PRIORITIES	Housing-related needs	Compliance with terms of rental agreement
DETERMINATION OF SERVICE INTENSITY	CTI work is organized into phases of decreasing intensity with ultimate goal of transitioning to community support	Service delivery and intensity is determined by what a client needs in order to comply with a standard lease agreement
SUBSTANCE ABUSE PARAMETERS	Substance abuse may be addressed as part of one of the priority treatment areas.	No required period of sobriety prior to housing; substance use is addressed through a harm reduction approach
COMPLIANCE	Must be compliant with services and treatment supports	Must be compliant with terms of lease
LONG-TERM PLAN	Establish solid connections with community-based resources and supports that can address ongoing needs	Maintain housing

Stages of Change Overview⁴

The Stages of Change framework was developed by observing and identifying the natural stages through which people move as they make changes on their own, without professional intervention. Because the Stages begin before a person has made a decision to change a particular behavior, it is especially relevant for HUD-VASH Case Managers as they acknowledge that their clients may be in denial of certain problem behaviors.

The model identifies which interventions will be most effective at each stage to help a person move forward in the process of change. The model also sees relapse to the problem behavior as a part of the process and normalizes setbacks. The Stages of Change model has been particularly effective in treating clients with substance use disorders, but can be applied to other problem behaviors as well. The stages described below are used to achieve these goals.

The Stages of Change and Recovery are

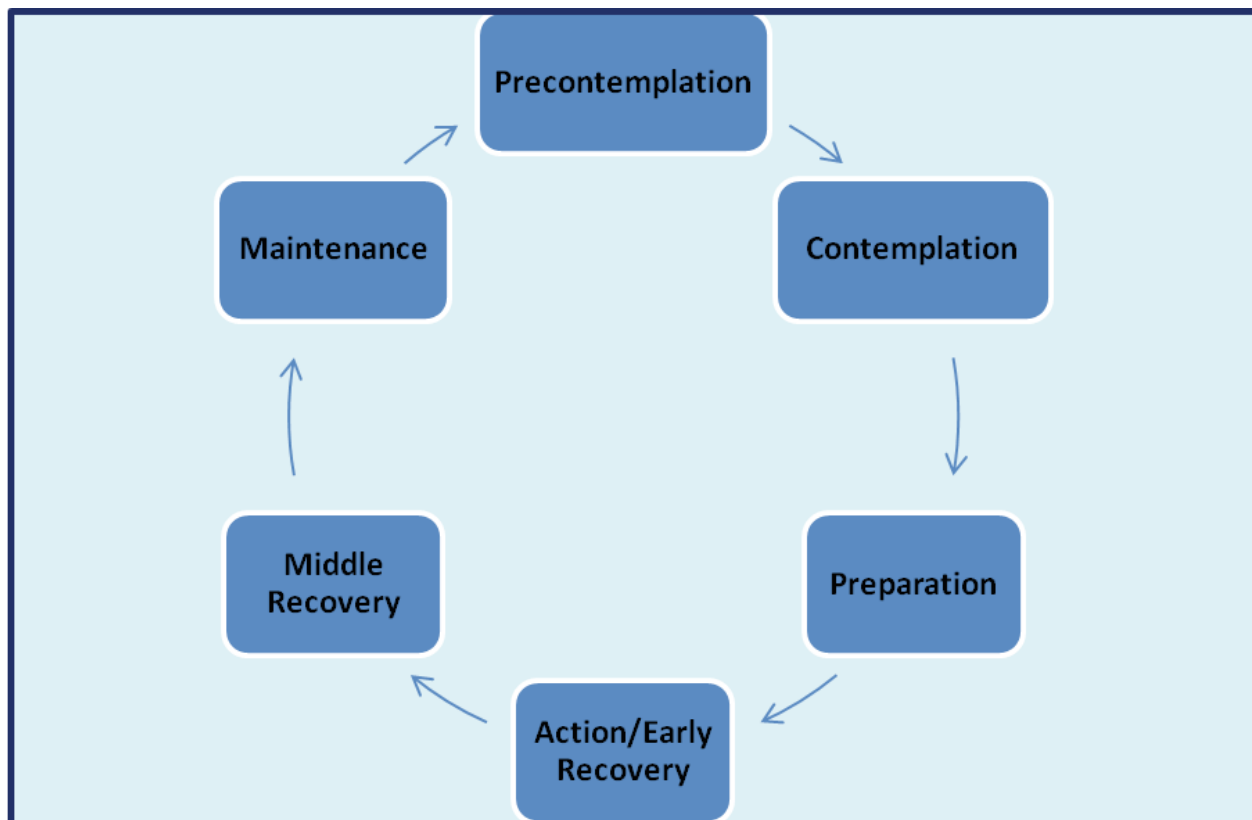
- **Pre-contemplation:** unaware that problem exists, no plan for change

- **Contemplation:** aware the problem exists and thinking about options for change
- **Preparation:** motivation is building for change and the person is starting to think about the specific plan for changing (e.g., setting a “quit” date)
- **Action/Early Recovery:** person is beginning to make change and has maintained it for less than 6 months
- **Middle Recovery:** person nears six months of consistent behavioral change
- **Maintenance:** change has been sustained for at least 6 months; client is now working towards achieving other goals

The Stages of Change model will be particularly helpful when working with Veterans who are having trouble with their housing situation, but are not ready to make a change. Chapter 6, “Challenges to Housing Stability for Homeless Veterans,” discusses this model’s application in greater depth.

The diagram below illustrates the Stages of Change and Recovery.

⁴ Prochaska, DiClemente and Norcross, 1992. In Search of How People Change: Applications to Addictive Behaviors.



Motivational Interviewing Overview

A key role of the HUD-VASH Case Manager is to building motivation for change. Thus, Motivational Interviewing techniques are often used in conjunction with the Stages of Change model described above. For those who have experienced homelessness or other setbacks in life, hope and motivation may be sapped. Motivational techniques focus on creating a partnership with the client and eliciting and amplifying the person's own reasons to change. According to Miller and Rollnick,

“Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.”⁵

“There are ... specific and trainable therapist behaviors that are a characteristic of the motivational interviewing style. Foremost among these are

- *Seeking to understand the person's frame of reference, particularly via reflective listening;*
- *Expressing acceptance and affirmation;*
- *Eliciting and selectively reinforcing the client's own self motivational statements, expressions of problem recognition, concerns, desires, intention and ability to change;*
- *Monitoring the client's degree of readiness to change, and ensuring that resistance is not generated by jumping ahead of the client; and*
- *Affirming the client's freedom of choice and self-direction.”⁶*

Comprehensive information on using Motivational Interviewing with HUD-VASH clients can be found in Part 2 of this Resource Guide).

⁵ Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy*, 23, 325-334.

⁶ Rollnick and Miller. (1995).

Overview of Housing Stabilization Planning

Once the Housing Assessment has been completed (see Chapter 3) and the Veteran is ready to enter the HUD-VASH program, the next step is to create the Housing Stabilization Plan.

Development of the Housing Stabilization Plan

The Initial Housing Stabilization Plan should be developed as soon as the Veteran is admitted to the HUD-VASH program.

The Veteran's motivation to achieve the goals in the plan is increased when the work in the near term relates to his/her long-term aspirations and plans. Thus, the Housing Plan should include the Veteran's long-term housing and life goals and all current work should be related to the achievement of the long-term plan.

- **The Initial Housing Stabilization Plan/Pre-Voucher Phase** focuses on tasks that need to be completed to submit the Voucher application to the PHA (the Pre-Voucher Level of Case Management). This includes gathering proper proof of identification, proof of income and assets, and identification of housing preferences (location, type of unit), etc. More information on vouchers is located in Chapter 4.
- **The Updated Housing Stabilization Plan/Voucher Phase:** The Plan should be updated once the voucher is issued to include location of a housing unit as well as plans for obtaining furniture, providing a security deposit, turning on utilities, applying for benefits, etc.
- **The Updated Housing Stabilization Plan/Housed Phase:** the Housing Stabilization Plan should be updated once a housing unit has been secured and a move-in date has been scheduled. The updated plan should identify the next set of goals for the transition (e.g., enrolling children in school, finding a place of worship, connecting with AA or NA groups, etc.). This marks the start of CTI Phase 1: Transition to Community.

CTI provides a structure for assisting people at a critical point of intervention—when they are transitioning to community-based housing. The HUD-VASH Case Manager is very involved in the Transition to Community phase of CTI, however as the Veteran becomes more comfortable, the Case Manager’s involvement begins to decrease, which marks the beginning of CTI Phase 2: Try-Out, where the Veteran begins accessing community-based resources on his/her own. During this time, the Veteran relies increasingly on community-based, mainstream resources and supports that the HUD-VASH Case Manager helped the Veteran identify and connect with during the Transition to Community Phase. In CTI Phase 3: Transfer of Care, the HUD-VASH Case Manager has successfully transferred care to other community-based providers and the Veteran has successfully demonstrated the ability to access these supports on his/her own.

The plan should be updated every three months after the Veteran’s move to the housing unit, paralleling the 3 phases of CTI:

- 1) Transition to the Community
- 2) Try-Out Phase
- 3) Termination/Transfer of Care or Step Down

Setting Goals

Using the principles of CTI, the Housing Stabilization Plan is focused on goals that are set by the Veteran and the Case Manager that address the Veteran’s most pressing needs. In the initial Housing Stabilization Plan, these goals should reflect the focus on the causes of the current housing crisis and prior instances of housing instability. Reviewing the housing assessment, especially the housing history and causes of homelessness, can help the Case Manager identify what should be included in the plan.

The connection of short-term goals to long-term goals is essential for building motivation. For example, budgeting can be linked to the desire to save for a gift for a child or loved one, a new TV or computer, or another item that represents the Veteran’s longer-term goals.

Following the CTI model, goals should be easily classifiable into one of the following areas, each of which is critical for making a successful transition to

community living:

- Housing Access and Retention
- Income, Employment and Finances
- Health and Mental Health
- Substance Use
- Life Skills and Supports
- Family and Friends

Each goal should have a target date for completion and a list of associated tasks. Some of these tasks will be the responsibility of the Veteran, and some will fall to the Case Manager. For both parties, the steps toward achieving goals should be clearly defined and measurable. It is helpful to choose between one and three goals for each Veteran at any given time.

A note about community-based resources and supports

In most cases, achievement of the goals in the Housing Stabilization Plan will require connections to other resources, supports, and services in the community—beyond what the VA can provide. Identifying community resources and linking the Veteran’s household to them is a critical task and one that can be very time-consuming for the Case Manager.

The HUD-VASH program encourages the Case Manager to arrange linkages to community resources, as this is critical to ensuring housing stability. For example, if a member of the household has no health insurance, but has a chronic medical condition, medical costs can make it difficult to make rent payments. Thus, linking the family with the State Health Insurance Program may provide critical financial relief. The HUD-VASH Case Manager is encouraged to assemble a central list of community resources and services which can be expanded and updated over time.

Monitoring and Updating the Housing Plan

The Housing Stabilization Plan should be updated at least every 3 months. This is an adaptation of CTI that sets time frames for accomplishing the work that needs to be done. This also allows the Case Manager and the Veteran to be motivated by progress and successes to date. As the transition to housing is stressful on many levels, new needs and issues often emerge that have not been identified in earlier assessments. Linking each Veteran with community-based resources requires time, attention, and deliberate care. As some connections grow and take shape, others may not be a good fit. Therefore, the Case Manager may need to adjust the plan accordingly. Updating the plan involves reviewing goals and tasks from the last plan, recording progress to date, and noting barriers to success. This also requires an update of the housing assessment to identify changes in status. When the plan is updated, goals may be revised, completed or discontinued; time frames should be adjusted as appropriate. Additionally, there may be a need to secure new services or resources, or to intervene to improve the effectiveness of linkages that have been made.

A note about expectations for goal attainment

The process of goal achievement will not likely be linear; there will be progress, setbacks and revisions along the way. Using Motivational Interviewing techniques can help resolve ambivalence about change and build forward motion.

Case Management after the Veteran Has Obtained the Voucher

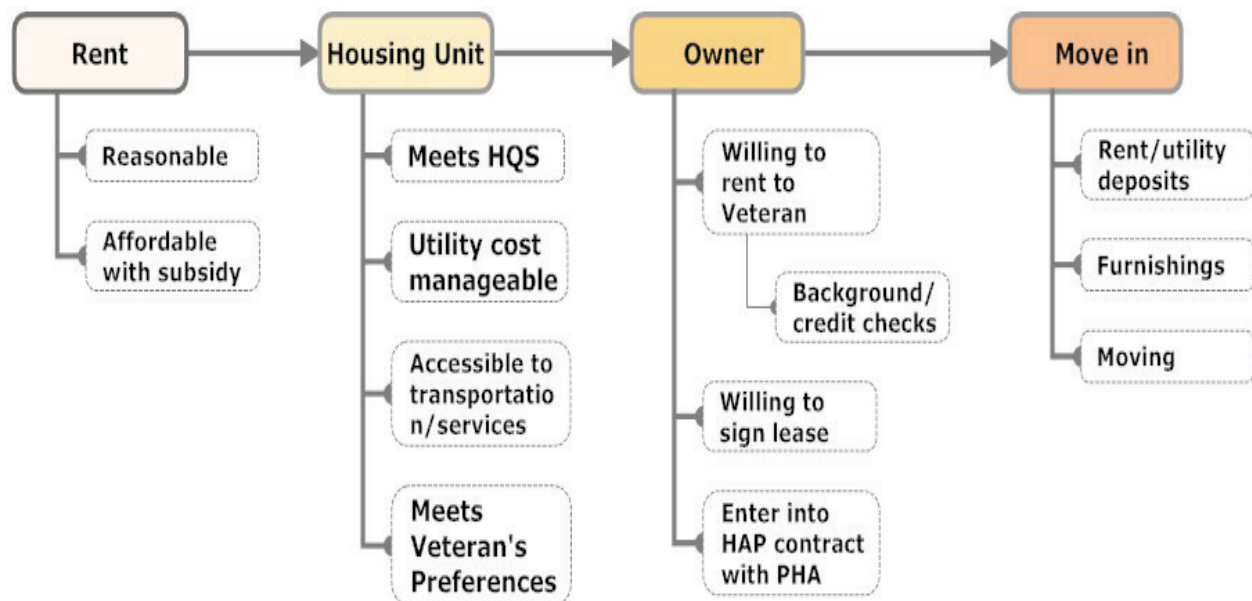
Securing Housing

Upon receiving a voucher from the PHA, the Veteran must then proceed to secure housing in the community. The Veteran must find a unit

- Where rent is affordable with the subsidy,
- That meets the Veteran's preferences, and
- Where the owner of the property is willing to rent to the Veteran and to accept the lease terms required by the PHA.

In addition, the Veteran must acquire sufficient resources to cover deposits for rent and utilities and for furnishing the unit.

The diagram below illustrates the steps that must be completed.



120-Day Clock, Extensions and Re-Referral

In the HUD-VASH program, the Veteran has a maximum of 120 days in which to locate a unit and submit a Request for Tenancy Approval (RTA). Once the RTA has been submitted to the PHA, the 120-day 'clock' is suspended until the PHA inspects and either approves or disapproves the unit.

If the Veteran is unable to secure housing in the 120-day search period and requests an extension, PHAs follow the procedure specified in their respective Administrative Plans. HUD does not require PHAs to grant extensions, and some do not. In the regular HCV program, applicants who are not able to locate a unit lose the opportunity for the subsidy, and the voucher is offered to the next household on the waiting list.

(If the Veteran is disabled and unable to find a rental unit for reasons related to his or her disability, then a reasonable accommodations request for an extension would have to be approved by the PHA.)

In the HUD-VASH program, Veterans do not go onto a PHA waiting list. Depending on the availability of HUD-VASH vouchers at a local VA, Veterans may be placed on an 'interest list' until a HUD-VASH voucher is available. The VA has sole authority over which Veterans will be referred to its partner PHA. This applies to both initial referrals and re-referrals of Veterans who are terminated for any reason. Re-referral is at the discretion of the VA Case Manager, if it is determined to be appropriate for ending homelessness for the Veteran. Upon re-referral, as on initial referral, PHA screening is limited to lifetime registry on sexual offender lists and income eligibility for Housing Choice Vouchers. Veterans can be re-referred if they were unable to locate housing in the 120-day search period, if they were evicted, and even if they have outstanding debts to the PHA or another housing provider.

If a Veteran is re-referred, the PHA will need to do all the work required to issue a new voucher. For this reason, it often makes more sense for the PHA to grant an extension to the Veteran or not terminate Veterans from the voucher program, even if this is an exception to their general policy. It is important for HUD-VASH staff to discuss this situation with the

PHA to create the most efficient system for both the housing authority and the Veteran.

In situations when the Veteran is not able to locate suitable housing, Case Managers should assess why the Veteran has been unable to locate housing. Additional resources should be devoted to supporting the search process. Also, Case Managers should examine whether an alternative type of housing would be more appropriate for the Veteran. If the need for additional search time exists, it should be discussed in joint meetings with the PHA.

Understanding Utilities

In calculating gross rents for units leased through HCV, PHAs must consider utilities that the tenant will pay as well as the contract rent to the owner. The request for tenancy approval must specify which utilities are the responsibility of the tenant, and which are included in the rent. Each PHA is required to establish a utility allowance schedule (based on the utility costs of energy-conserving households occupying similar units in the community) to cover reasonable allowances for tenant-paid utilities. The amount of subsidy that can be provided to cover contract rent is diminished by the utility allowance for non-landlord provided utilities. Furthermore, utility allowances that are based on 'energy-conserving' households often do not cover all expenses that Veterans will face, especially as they adjust to having a place of their own.

Veterans are responsible for paying for non-landlord provided utilities. An interruption in utility service because of a Veteran's failure to pay is considered a breach of the obligations under the HCV program.

HUD-VASH Case Managers should assist Veterans in controlling utility costs in the initial search process to ensure low ongoing costs. Utility costs should be assessed as part of the housing search process, and some units that appear affordable will not be after utilities are factored into monthly costs. Formerly homeless Veterans have very limited resources and can be financially overwhelmed by utility costs.

First preference should be given to housing in which all utilities are included in the rent. This is something that can be negotiated with landlords. When

angling for utility inclusion in monthly rent, stress to the landlord that the HCV subsidy provides a guaranteed income, and that the tenant is a Veteran.

Veterans should also consider new affordable housing developed with support from HUD or low-income housing tax credits. Newly-developed housing will almost always have a higher level of energy efficiency.

Later on in this chapter, you will find an overview of other types of HUD assistance and a discussion of housing location considerations.

Working with Landlords

Both the landlord and the Case Manager have a vested interest in the Veteran's ability to maintain housing. This means that the landlord can be confident in regular rent payments, an adequately maintained unit, and no complaints from other tenants. For the VA, stable housing means an end to homelessness and the opportunity to help the Veteran build positive momentum from the stability that decent, affordable housing can provide.

In the HCV program, HUD provides subsidies to make housing affordable, but relies on the private sector to provide the housing. Property owners can be small landlords that own a few housing units, larger property owners, developers and owners of affordable housing, and non-profit community development organizations. The HCV program provides property owners with the opportunity to select tenants who they feel will meet the obligations of tenancy.

Although HUD eliminated the screening procedures that PHAs use for the regular HCV program, there are no similar prohibitions against landlords using credit checks, criminal background checks, or other forms of screening, provided it is non-discriminatory. Some landlords may be reluctant to rent to program participants because of past housing history and concerns that the tenancy will be problematic.

Some Veterans will need additional assistance locating housing that meets their preferences and landlords willing to rent to them. There are a number of resources that HUD-VASH Case Managers

can use to identify property owners who might be willing to rent to formerly homeless Veterans. These include

- **Property owners who participate in Continuum of Care Homeless Assistance Programs.** The Continuum of Care (CoC) programs, supported by HUD, frequently rely on private property owners to provide permanent and transitional housing. These landlords are already willing to rent to homeless people, receive government subsidies, and have their properties inspected by government agencies. Each CoC has a lead contact. In the event the VA Case Manager does not have existing relations with local CoCs, <http://www.hudhre.info/index.cfm?do=viewCocContacts> provides contact information for all CoCs in the country.
- **References from landlords who are currently participating in HUD-VASH.** It is important to maintain positive relations with landlords who participate in HUD-VASH for many reasons. If their experiences are positive, these landlords might be willing to serve as references, rent to other Veterans, or refer other property owners for participation in the program.
- **Affordable housing developers.** HUD, as well as state and local governments, provide substantial support to the development of affordable housing through grants, low-interest loans and tax credits. In return, developers are generally required to rent the housing to low- or moderate-income households for a specified period of time. Since these developers are required to rent to low-income families, the presence of a long-term subsidy such as HUD-VASH can help them fulfill their obligations while maintaining adequate revenue. Each municipality has a community development agency and state governments have housing finance and/or community development agencies. These agencies should be able to provide a listing of, and all contact information for, all affordable housing that they have supported.

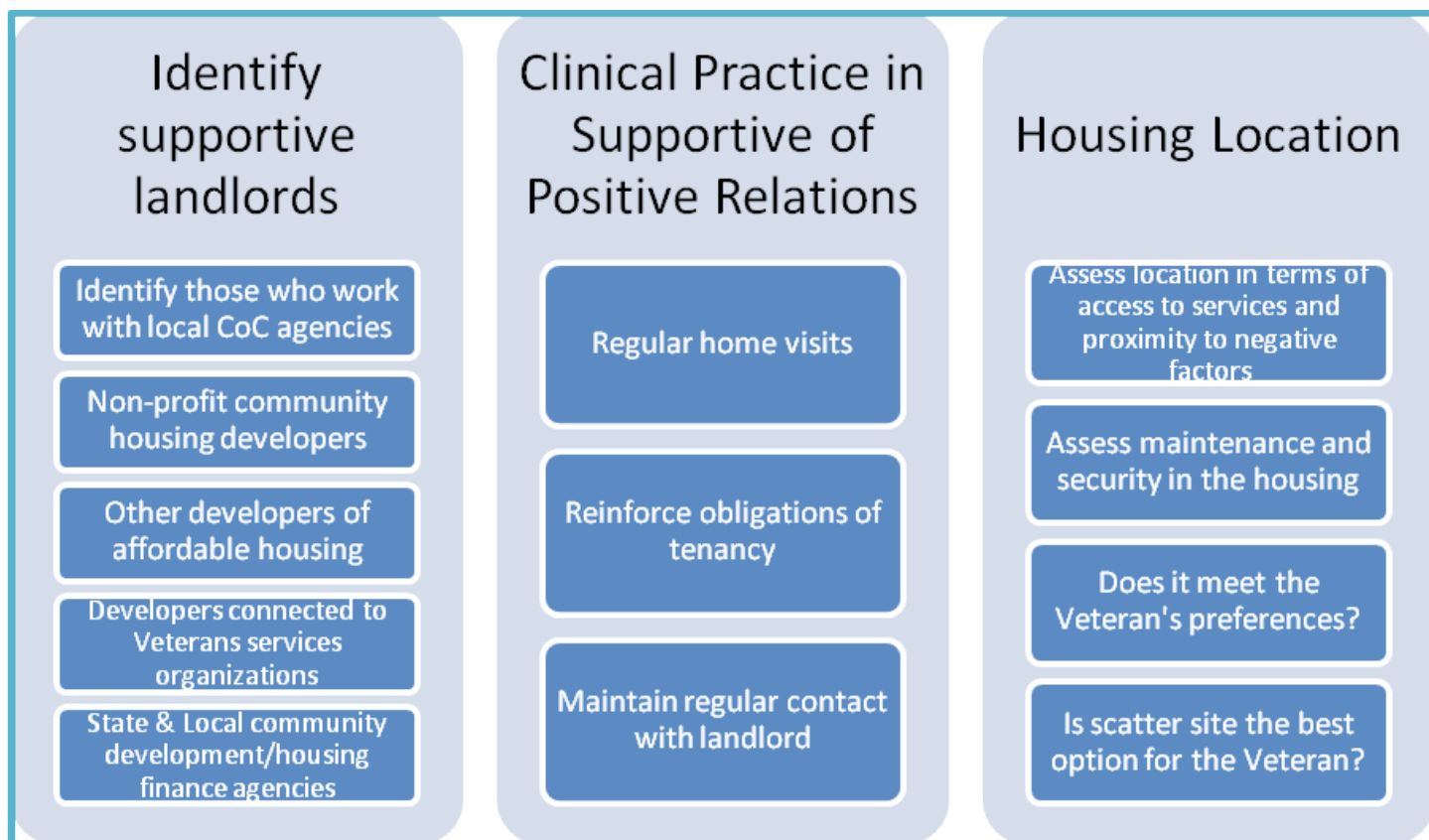


Figure 1 Summary of Strategies to Secure Landlord Involvement

- **PHAs.** PHAs will generally maintain lists of landlords who have been willing to participate in the regular HCV program. These landlords have experience meeting HCV requirements and providing housing to HCV-eligible households. In areas where the housing market has been impacted by the financial recession, there is strong landlord interest in participation.

Clinical Practice in Support of Positive Relations with Landlords

The exit from homelessness, and the transition to housing, can be very stressful. For example, some people lack knowledge and skills regarding housekeeping. Others experience extreme loneliness when they finally close the apartment door that separates them from the rest of the world. Still others quickly come to realize that their housing is a valuable commodity that potentially could be traded or exchanged.

The active involvement of the HUD-VASH Case Manager—especially in the period immediately following placement in housing—is critical to ensuring housing stability. In the initial months of occupancy, there should be regular weekly home visits to monitor the transition and troubleshoot potential issues. The Case Manager should assess housekeeping skills, identify whether the Veteran needs additional supports such as a home attendant or live-in aide, and determine if the Veteran is meeting the obligations of tenancy.

It is also recommended that the Case Manager maintain regular contact with the landlord, especially in the first months of occupancy. Regular phone calls, on or about the 10th of the month when rent should have been paid, should be made to the landlord. It's generally sufficient to initiate contact; if the landlord has any problems with the Veteran, he/she will probably bring them up. Case Managers need only report that they are 'touching base' to see if there are any problems or if there is anything they can do to help.

HOUSING LOCATION VS. NEEDS CHECKLIST

YES	NO	HOUSING NEED	CONSIDERATION
		Is the unit close to the VA where the Veteran will be receiving services? Is transportation readily available, convenient, and affordable?	ACCESSIBILITY
		Is unit located close to, or within convenient distance of public transportation to, the community-based providers with whom the Veteran might be meeting?	
		Does the Veteran want to live close to family or other supports that may be helpful in maintaining recovery? Does the unit fulfill this preference?	COMMUNITY
		Is the unit itself in a location where the Veteran might have used drugs or engaged in other negative behaviors?	LOCATION
		Is the unit near a location where the Veteran might have 'hung out' with old associates? Is there a risk that the apartment might become a new hang-out location?	

Landlords should be informed of the role of Case Managers, and should be encouraged to use them as a resource to assist in resolving problems. Case Managers should stress that, if problems arise, their role is to intervene long before a landlord reaches the point of considering terminating a tenancy. Case Managers should become familiar with the terms of each lease, and continually reinforce the obligations of tenancy with the Veteran.

Issues to Consider in Housing Location

Access to transportation is crucial. Veterans will need to be able to access services from the VA and other community-based providers.

Case Managers should consider clustering apartments—searching for and placing veterans in units in the same, or adjacent, housing complexes. Clustered housing can assist the Case Manager by making it easier and more efficient to conduct home visits. Furthermore, the presence of other Veterans nearby could be helpful in maintaining housing stability. Loneliness could lead the Veteran to engage in harmful behaviors that may cause him/her to lose the housing unit. Clustering apartments can help forestall this.

Additional Resources for Housing Location

A widely used on-line resource to assist households holding vouchers is called 'Go Section 8' which can be found at: <http://www2.gosection8.com/>. The extent of the listings varies from locality to locality, but, in general, this is a useful, free resource. Units listed will be within applicable Fair Market Rents (FMRs) and the listing provides information on housing type and amenities. Frequently, photographs are included.

Other Resources:

- **State housing finance agencies.** These agencies are responsible for distributing Low Income Housing Tax Credits to developers of affordable housing. They maintain lists of tax credit-supported housing. Each of these developments provides high quality housing at rents that are affordable to voucher holders. Each development will have its own policies for screening eligible tenants, and some VA Case Managers have reported difficulty in accessing this housing for homeless Veterans. However, given that the housing is of good quality and energy efficient, it is worthwhile to pursue these developments as a possible housing resource.
- **Community development organizations.** There are non-profit community development organizations in most metropolitan areas.

They use HUD and local resources to develop and operate affordable housing. They can be identified by contacting local municipal governments (community development/revitalization agencies). These organizations should be sympathetic to the goals of the HUD-VASH program and understand the value of the housing subsidy.

Assisting with Community Integration

Once the Veteran has housing, the primary focus of HUD-VASH case management is to reduce the difficulty associated with community transition. While connecting the Veteran to needed community-based treatment services is a primary goal of HUD-VASH, this is framed in the context of housing stability. CTI has proven effective in helping individuals from a variety of institutional settings, such as emergency shelters, psychiatric hospitals, and jails/prisons, transition into permanent housing. Key principles of CTI assessments include prioritizing needs and setting goals, as discussed in previous sections. Additionally, the model focuses on connecting clients to mainstream resources and reducing the intensity of case management as the Veteran begins to rely on community-based services and supports. As such, CTI-driven Case Management work is organized into phases of decreasing service intensity, guided by the extent of the Veteran's ability to effectively engage other systems. The following section describes the focus and tasks for each of the three phases of CTI.

Phase 1: Transition to the Community

Once the Veteran is under lease and in HUD-VASH, the focus is on the transition to the new unit and neighborhood. While getting a new home is generally thought to be a positive experience, it is also almost always stressful. Thus, the Case Manager needs to be especially active in monitoring the Veteran's adjustment. At a minimum, this usually means weekly contact and visits to the home at least twice during the first month of tenancy.

During this phase, the Case Manager helps the Veteran set up the home and learn about the

neighborhood, also ensuring that basic needs are being met (e.g., banking arrangements, transportation, grocery shopping, child care, etc). During this time, the Case Manager is also monitoring any problems that could jeopardize tenancy. While this list of behaviors is long, the Case Manager looks for problems with rent or money, behavior issues (noise, conflicts with neighbors, lots of visitors), and unkempt units. As neighborhood and local services will be essential in ensuring integration and housing stability, preliminary identification of community resources should occur, and initial referrals and connections should be made.

Phase 1 Case Manager Role and Tasks

- Continue engagement
- Update Housing Assessment with housing information and, particularly, with risks to housing stability
- Adjust the Housing Stabilization Plan
- Assist with setting up home and getting settled in community
- Begin intensive, assertive outreach to develop linkages to community resources
- With Veteran consent, establish working relationship with landlord
- Evaluate the Veteran's living skills and begin steps to improve areas of limited experience/knowledge
- Support the "settling in" process. Make sure the Veteran knows how to deal with repairs, complaints and other problems in the unit
- Provide education about tenancy rights, responsibilities, and expectations
- Model negotiation skills
- Monitor safety in the household – especially in cases with histories of domestic violence, child abuse/neglect, other violence, or suicidal/homicidal ideologies
- Meet at least weekly

Phase 2: Practicing/Try-Out Phase

The Practicing/Try-Out Phase begins about three months after a Veteran is housed. He or she has

settled in and is meeting the basic needs of the household. He or she has been connected to community-based resources, and now the Case Manager is evaluating how these supports are working and whether interventions are needed. The Case Manager is in contact with both the Veteran and the service providers to help support these connections. The Case Manager is also updating his or her assessment of the Veteran and the Housing Plan as goals are achieved and new needs emerge.

In this phase, the Case Manager is working with the Veteran on living independently and adjusting to a new role in the community. While some people will still need assistance making a schedule and planning and organizing tasks and time, others will be ready to start to plan for goals unrelated directly to housing, such as going back to school, training for a new career or getting into or re-connecting a relationship.

Still others may be experiencing problems maintaining their housing. Within 3 months, problems like getting behind on rent, having too many loud parties, collecting items that cause health hazards, and other threats to housing stability may be emerging. The Case Manager must be frank about the risks posed by these behaviors, framing them in terms of continued tenancy, and should help the Veteran by discussing options for resolving problem behaviors and maintaining the unit.

Phase 2 Case Manager Role and Tasks

- Update Assessment, Housing Barriers and Housing Stabilization Plan
- Monitor and solidify linkages to community resources—this might include legal assistance, schools for children, religious/spiritual connections, community treatment and support systems
- Adjust linkages and make new referrals as needed
- Keep in contact with other community-based service providers and have joint service planning meetings as authorized by the Veteran
- Keep in touch with landlords and monitor for threats to housing stability, including late

rent payments, problem visitors, etc. Where problems exist, work to help the Veteran adjust behaviors. Use Motivational Interviewing, and link desired changes in the short-term to achievement of long-term goals.

- Promote independent living skills
- Verify banking procedures and income stream, discuss financial management, reinforce tenancy obligations
- Check-in regarding utility payments and other additional financial responsibilities
- Conduct regular meetings with Veteran to monitor progress and solidity of connections. Visit the Veteran at home at least monthly, and, unless the Veteran does not need support at that level, check in weekly by phone.
- Develop longer-term plan. Consider less acute needs such as education planning, career goals, and planning for the future.

Phase 3: Step Down/Transfer of Care/Termination

As the Veteran stabilizes, he or she will become less reliant on the Case Manager and more connected to community resources. As this occurs, it may be possible to reduce the frequency and intensity of services. This will happen at different points for different people; however, for many, after about six months of stable housing, it may be possible to start stepping down the level of service.

Even if it is appropriate to ease into a less central role, it is essential that the Case Manager is still aware of the Veteran's situation. He or she is still vigilant for threats to housing stability and continues to update the plan accordingly. The Case Manager is also checking on the depth and breadth of community involvement, making adjustments, and providing new referrals as needed. If the Veteran is interested in pursuing other recovery goals, the Case Manager should provide guidance and support.

In some cases, the Case Manager and the Veteran may agree that case management services are no longer needed. Indeed, this represents success, as the HUD-VASH Handbook states that graduation

from case management is a program goal.⁷ When the Case Manager also agrees that housing stability is no longer dependent upon VASH services, the Veteran can continue to receive the voucher alone. If the PHA has another voucher available, one that does not include a case management services allocation, they may choose to switch the Veteran to that voucher, thereby freeing up a HUD-VASH voucher for another homeless Veteran. A number of PHAs have 'graduated' HUD-VASH holders to regular vouchers.

Veterans who transition from a HUD-VASH voucher to a regular voucher do not have to be on the PHA's waiting list. As a current participant in the HCV program, they can transfer to the next available voucher.

Phase 3 Case Manager Role and Tasks

- Update Assessment Housing Barriers and Housing Plan
- Maintain regular, if less frequent, contact with the Veteran
- Fine-tune linkages and make new referrals as needed
- Begin or continue to address other non-housing related issues, such as career and education goals, social or family re-connections, recovery and wellness
- Continue to monitor risks and threats to housing stability; continue to check in with the landlord
- As appropriate, terminate case management services with the client. This includes a review of the Veteran's progress planning for continued housing stability. Termination can be difficult for both the Veteran and the Case Manager. It is important to acknowledge the loss and recognize the value of the joint accomplishment. Supervisors will need to help Case Managers with these transitions during the supervision and case conferencing processes.

A note on discharge from case management

The case management model is meant to be flexible and adjust according to the Veteran's needs over time. Services may continue if a Veteran enters treatment and, in fact, the HUD-VASH Case Manager functions as an important bridge, ensuring continuity of care. Deciding to terminate case management should be made in consultation with the Case Manager's supervisor; other VA mental health or Homeless Patient Aligned Care team staff staff, as indicated; and the VISN Homeless Coordinator.

Key Practices

Housing Stabilization Plan

- Set one to three goals based on the highest priority threats to housing stability identified for each Veteran from the six primary CTI treatment areas (housing, health/mental health, substance use, life skills, financial, and family intervention)
- Ensure goals have target dates
- Include clearly defined tasks needed to achieve goals for both Veteran and Case Manager

Phase 1: Transition to the Community

- Maintain weekly contact with Veterans in the first month, including at least two home visits
- Check-in with landlords around the 10th of the month
- Evaluate and build independent living skills, including housekeeping skills and other skills required to meet obligations of tenancy
- Create personalized lists of community resources with Veterans to build community connections

Phase 2: Practicing/Try Out Phase

- Conduct monthly home visits and maintain weekly contact, unless unneeded by Veteran
- Monitor Veterans' use of community supports and intervene if necessary

⁷ Department of Veterans Affairs (2009). VHA Handbook 1162.05. HUD-VASH Program Manual. Washington DC, 16.

- Update Housing Stabilization Plan with progress on goals and notes on barriers and include longer term plans to reflect transition to new phase

Phase 3: Step Down/Transfer of Care/Termination

- Reduce frequency of services as warranted
- Update Housing Stabilization Plan with progress on goals and notes on barriers and include non-housing related goals and plans (e.g. career and education goals, social/family re-connections, recovery and wellness)

Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your knowledge about HUD-VASH case management.

- 1) The HUD-VASH case management approach differs from other service modalities in that the goal of services is focused on housing stabilization.
- 2) HUD-VASH case management helps people find homes and then provides services for as long as necessary to ensure residential stability.
- 3) Case Managers should rarely go to a Veteran’s home in order to protect privacy.
- 4) Critical Time Intervention (CTI) can be used with families as well as single adults.
- 5) In Housing First approaches such as HUD-VASH, housing is not contingent upon compliance with services.
- 6) The Stages of Change approach sees relapse to the problem behavior as a part of the process and normalizes setbacks.
- 7) According to Miller and Rollnick, “Motivational interviewing is a top-down approach that offers professional decision-making for those who would otherwise not be able to make decisions for themselves.”
- 8) A housing stabilization plan should be developed within the first 6 months of a Veteran moving into housing.
- 9) It is helpful for the Veteran and Case Manager to choose between one and three goals.
- 10) Although HUD eliminated most screening criteria for Veterans to receive vouchers, there are no similar prohibitions against landlords using credit and criminal background checks.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) Can you name three of the four principles of Critical Time Intervention?
- 2) What are some of the critical elements of Housing First and why are they important in HUD-VASH case management practices?
- 3) Which stages of change occur prior to Action & Early Recovery?
- 4) Identify a time when you used a motivational interviewing style.
- 5) How is a Housing Stabilization Plan developed? How will you incorporate this practice into your HUD-VASH case management work?
- 6) What are some resources that might help to identify property owners who might be willing to rent to formerly homeless Veterans?
- 7) What are some ways a Case Manager can address safety during home visits?
- 8) What are the three phases of CTI? What are some of the key practices your team can implement in each of these stages?

Challenges to Housing Stability for Homeless Veterans

What's in This Chapter?

Permanent supportive housing is the most promising solution for ending chronic homelessness. Chronically homeless Veterans—including those who cycle between streets and shelters; who are frequently, episodically homeless; and who are struggling with physical or mental health problems—have been repeatedly failed by other housing programs, traditional services systems, and stop-gap assistance. HUD-VASH's primary goal is to help Veterans with these experiences succeed in housing.

In this chapter you will learn how to

- Identify barriers to housing;
- Recognize, prevent, and ameliorate recovery-based threats to housing stability;
- Build motivation through the stages of change; and
- Work proactively with Veterans and their landlords to ensure continued tenancy.

After reading this chapter, you will be able to identify barriers to housing before they happen and know how to work proactively with Veterans and their landlords to prevent evictions.

Introduction to Housing Stability Barriers

Once a Veteran is housed, the focus shifts from *obtaining* a residence to *maintaining* it. There are a variety of reasons and circumstances that a household's tenancy may be threatened. These include

- Nonpayment of rent: In HUD-VASH, the tenant is responsible for paying 30% of income or the minimum rent (unless a waiver has been granted);
- Disrupting the peaceful enjoyment of other residents by making noise, having problem visitors, and/or engaging in criminal activity; and
- Health and safety issues, such as hoarding, lack of sanitary conditions, utility shutoff.

Reasons for these problems include

- Inability to pay utilities due to limited income;
- Financial management problems;
- Limited experience as a lease holder and inability to meet, or unfamiliarity with, tenancy obligations;
- Lack of skills requisite for the activities of daily living;
- Cognitive impairments – trouble remembering, disorganization, trouble with dates;
- Medical, mental health (including PTSD) or substance use issues;
- Unforeseen expenses/emergencies, such as medical bills or car problems.

Preventing Housing Instability

As Case Managers are working with Veterans to access and maintain housing, a few key interventions can help to prevent housing crises before they occur. The following chart outlines important Case Manager tasks.

CRITICAL TASKS FOR PREVENTING HOUSING INSTABILITY

DOMAIN	CASE MANAGER TASKS
PLANNING	<ul style="list-style-type: none"> ▪ Create a detailed Housing Stabilization plan.
AWARENESS	<ul style="list-style-type: none"> ▪ Make home visits at least monthly but more frequently at first and in cases of housing instability.
HOME MAINTENANCE	<ul style="list-style-type: none"> ▪ Provide education about maintaining a home – repairs, cleaning, etc. ▪ Arrange or provide life skills training. ▪ If help is required to maintain personal or environmental hygienic standards, arrange support such as home health aides.
LANDLORD-TENANT MEDIATION	<ul style="list-style-type: none"> ▪ Keep in contact with landlords as authorized by the Veteran. Preferably, arrange that landlords will contact VASH Case Managers whenever there are problems with rent or other lease violations. ▪ Provide education about expectations of tenancy and what the lease says and means.
INCOME AND FINANCIAL MANAGEMENT	<ul style="list-style-type: none"> ▪ Focus on increasing/sustaining income by assisting with job applications, benefits, and entitlements. ▪ Review or help create household budgets; connect with financial literacy services. ▪ If needed, help arrange representative payee and/or direct vendor arrangements whereby the rent is paid by someone else or is automatically paid out of entitlements checks or bank account.
RECOVERY	<ul style="list-style-type: none"> ▪ Maintain connections to treatment, services and support systems to ensure services are provided. ▪ Communicate with primary care and mental health providers.

As part of the housing assessment discussed in Chapter 4, the housing history is an important tool in revealing past housing maintenance problems and exploring the Veteran’s experience as a lease holder (in some cases, this may be very limited).

Frank conversations with the Veteran around reasons for past housing loss, and ways to prevent future problems, are critical in creating the Housing Stabilization Plan (described in detail in Chapter 5). However, among chronically homeless Veterans, it

is also not uncommon to find limited experience as a lease holder. Younger Veterans, especially those from recent conflicts, may have very little experience living independently. In these cases, it is better to err on the side of providing more education about tenancy requirements.

Additionally, ensuring connections to peer and/or community support programs can help promote housing stability. Case Managers should use all the resources at their disposal to strengthen the

Veteran's foundations in both tenancy obligations and, if applicable, recovery and treatment goals.

Overcoming Barriers

When, despite all efforts, the Veteran's ability to maintain housing is in imminent danger, the response should be rapid and prompt. Regular ongoing contact with the Veteran, and with the landlord, if possible, can help with identifying problems before they become crises. Home visits often provide a wealth of information that an office visit cannot—illuminating underlying issues, and assisting with early identification of problems.

Dual Focus: The Behavior and the Veteran's Goals

Threats to housing stability present immediate problems (danger of eviction due to rent arrears, failure to maintain hygiene standards, etc.) with complex underlying causes (delay in benefits payments, relapse to drug abuse, mental health symptoms). In order to ensure that the Veteran retains his or her housing, the Case Manager must engage the Veteran on two fronts: first, with a philosophy of damage control and a focus on stopping or changing the problem behavior, no matter what its origin; and second, in a pro-active exploration of the underlying reasons and causes. This assessment will involve considering the Veteran's own self-identified goals, re-evaluating the Housing Stabilization Plan, considering intensification or modification of clinical services and/or peer support, and linking the Veteran to resources and supports that will help prevent similar problems.

For example, if the problem is rent arrears, the Case Manager should

- 1) focus on working to arrange a repayment agreement,
- 2) work with Veteran to develop actionable ways to stick to the plan,

- 3) link these actions with the Veteran's own recovery goals using the Housing Stabilization Plan,
- 4) continue to build motivation for the needed change, and
- 5) work to consider and understand underlying causes for the rent arrears, as this will help determine which interventions might be helpful. For example, if the cause of the arrears is over-spending due to manic behavior caused by Bipolar Disorder, a budget or representative payee arrangement may be the first step to resolving the issue. This may also be an opportunity to help the Veteran consider mental health services to get treatment for the mania, especially if it has caused other problems or interferes with achieving other goals (like saving for a computer, furthering educational goals). Case Managers are always looking for ways to link the Veteran's goals to recommended services. However, even if mental health treatment is not accepted and as long as there is a plan to ensure the rent is paid—the Veteran can still be stably housed.

Stages of Change and Building Motivation

In addressing obstacles to housing stability, the Stages of Change (SOC) model provides a useful framework for thinking about how to motivate the Veteran for change. SOC identifies the stages people normally go through as they change problem behavior. It differs from other interventions in its emphasis on "pre-change" stages of the process. The Stages of Change framework recognizes change as a non-linear process with setbacks and relapses; these are considered opportunities to learn.

The Stages of Change model is outlined below.

THE STAGES OF CHANGE	
STAGE	VIEWPOINT/CHARACTERISTIC
PRE-CONTEMPLATION	"No problem exists"
CONTEMPLATION	"A problem may exist"
PREPARATION	"A problem exists; I might consider doing something about it"
ACTION	Choosing alternate behaviors
MAINTENANCE	After the first six months of choosing alternate behaviors in the action phase, behavior becomes more habitual, and maintenance phase begins
RELAPSE	Presented as a normal part of the process and an opportunity to learn. After relapse, Veteran motivation to change may be at any of the first three phases.

Case management is most effective when interventions match the client's stage of readiness. In assessing a person's readiness for change, Case Managers should have the Veteran identify pros and cons across the spectrum of action. With the Case Manager, the Veteran should name and list the advantages and disadvantages for change—as well as the advantages and disadvantages of maintaining the status quo. By eliciting the Veteran's own motivations, and striving to understand the Veteran's decision criteria, the Case Manager can link needed changes with the Veteran's goals, thus building motivation. While external forces may seem to drive or compel change, lasting changes require internal motivations. To facilitate this, the Case Manager's key tasks are listening and exploring as HUD-VASH participants identify their own reasons to do the work required for recovery.

HUD-VASH links housing to health care and other resources, yet often people are not ready to utilize all of the supportive services to make changes. When a homeless individual is not ready to make changes, he or she may be resistant to outside advocacy for a certain change. As humans, we naturally work to maximize our options, and when someone else lists the reasons to adopt or reject a certain behavior,

we may resent a perceived limitation of choices. Instead, an effective intervention may be to gently and non-judgmentally raise awareness of how certain choices interfere with personal goals.

Using the rent arrears example, the Case Manager might reflect, "Spending so much money on clothes seems to be giving you trouble with your rent. Are there other saving goals that it's interfering with?"

While the Stages of Change framework was developed around addictive behaviors, practitioners have successfully used it for issues such as medication adherence, benefits, and entitlements.

Ongoing Efforts

Resolving barriers to housing stability will be an ongoing part of the work with some Veterans. Updating the Housing Barriers Assessments and Stabilization Plans keeps the focus on this critical aspect of the work. Understanding the Veteran's perspective on needed changes helps the worker to intervene more effectively. Continuing to connect behavioral changes to housing maintenance and achieving other self-identified goals will help build the Veteran's motivation for change.

Case Studies

The following case studies describe a variety of situations in which housing stability is threatened. For each case, the Case Manager's short-and long-term interventions are described.

Case Study: Rent in Arrears

George is a man in his 60's who has been in housing for six months. He came to HUD-VASH from a shelter and you were able to help him get his VA pension and then find an apartment. He had a few problems with his rent in the first few months but you helped him work it out. The bank will now send the check directly to the landlord and he was able to pay his arrears through assistance from a local church.

George likes his apartment and has promised to do better. He tells you things are good and, in fact, he has begun seeing his family again. His children are grown and he is happy to have contact with his children again, so he can enjoy time with his grandchildren.

On a recent visit, you are surprised to find out from the landlord he is 2 months behind on his rent. George explained that his son needed money for a car repair and he could not refuse. He is apologetic, and in order to stay ahead, he wants you to help him get some back rent money from his church.

George's Long-Term Goal: A normal life in the community, a role in his family

Short-Term Tasks:

- Help stabilize the crisis (eviction): help negotiate a repayment agreement with the landlord, seek emergency financial assistance and/or get George legal assistance
- Connect paying his rent to his goal of a normal life in the community

Long-Term Tasks:

- Work with George on planning expenses, including both rent and an emergency fund
- Develop a budget

Case Study: Noise Complaints

Joyce lives in an apartment with her three small children. She keeps to herself, does not talk to any of her neighbors, and is always with her children. Although Joyce is quiet, her neighbors report hearing screaming at night, and are complaining to the landlord that Joyce is "just strange." Additionally, the school has contacted the HUD-VASH Case Manager to report that the two older children are sleepy during the day.

Joyce is angry about the complaints. She says she has problems sleeping and often wakes up with bad dreams. She is worried that, if she takes medication to help her sleep more deeply, she might not hear her children if they need her. Now, not only does she fear that she will have to move, but she is thinking of home-schooling her children.

Joyce's Long-Term Goal: A good life with her children

Short-Term Tasks:

- Discuss the issues that are jeopardizing housing and threatening Joyce's long-term goals: always being tired, not sleeping, not being able to care for and protect her children, the complaints from the neighbors that put housing at risk
- Help Joyce negotiate with the landlord for some time to resolve the problems
- Educate her on options for sleep disorders and traumatic dreams. Explain that there are services and treatments that can help her sleep better. Explore the possibility of mental health treatment

Long-Term Tasks:

- Explore whether she is interested in connecting with other mothers with similar experiences
- Explore options for day care or baby-sitting for the youngest child so that Joyce can get a break during the day

Case Study: Utility Shutoff and Unkempt Unit

Joe moved into his apartment after completing drug treatment. He had been doing pretty well—

going consistently to treatment and to Narcotics Anonymous meetings. He decorated his apartment and talked about getting a job. But now, after about 6 months in housing, things have begun to change.

He talks about moving on with his life. He has a girlfriend and wants to spend more time with her. He has been seeing some of his old buddies and hanging out with them in a bar. He explains that alcohol is not his drug of choice, so it is okay to drink. He wants to put homelessness behind him.

Yet, when you visit him in his apartment, the electricity is shut off and the apartment is a mess. He wants you to leave.

Joe's Long-Term Goals: A home, a job, a relationship

Short-Term Tasks:

- Reiterate your role to help Veterans maintain stable housing and reach their goals
- Address the immediate crisis of the electricity being shut off by trying to get emergency financial assistance or agreeing to the utility company's payment plan
- Try to connect with him and what he is interested in now; frame his goals in terms of what is most important to him now—his relationship

Long-Term Tasks:

- Acknowledge that goals change; ask what is working for him. Focus on current housing and relationship goals
- Discuss whether he is happy in his apartment and how he got so behind on utilities
- Ask whether he sees the drinking as related to his problems paying utility bills. Assess whether he has reasons to stop or reduce alcohol consumption; raise awareness of how drinking creates problems for him.
- If he wants to stay in the unit, assist with developing a plan to pay all bills

Case Study: Health and Safety

Teresa was moving from one family member's house to another. She last lived with her sister, who had also taken care of her children while she was deployed to Afghanistan. When she could no longer stay with her sister, she was given a hotel room by the family shelter system. They helped her get into the HUD-VASH program.

Now, Teresa is tired and ashamed of her situation. She gets her kids to school, but is home with the baby by herself all day. She naps a lot. The house is a mess—food on the couch, dirty carpets, and wet diapers on the counters. The landlord is complaining. She says she is doing the best she can.

Teresa's Goal: A home and a life with her children

Short-Term Tasks:

- Work with the landlord to establish a timeframe to cure the violation
- Address the issue that puts housing at risk: not maintaining the environmental hygiene standards of the apartment. Provide assistance/training with initial cleaning, provide cleaning supplies and instructions, assess risk to the children.
- Connect to goals and assess if the apartment is working for her

Long-Term Tasks:

- Acknowledge Teresa's sadness and all that has transpired in her life; offer support
- Provide education about treatment, peer support, and other types of support groups; normalize her feelings
- Identify after-school programs, activities, and/or enrichment opportunities that will keep her children active and engaged and give her a break

Case Study: Occupancy and Noise Violations

Jack lived in an encampment for many years. He was seen as a leader there, often helping the other guys with medical care and benefits. He accepted housing after he got sick, but he still misses the camp. He is doing well in housing and is liked by the landlord and his neighbors.

He often has people staying with him. They don't usually stay long and, at first, everyone ignored it. Now, however, there is a woman staying with him who drinks and can be loud. She insults the neighbors, and when she told the landlord that she now lives there, the landlord decided he had enough. Jack is angry; his friend has no place to go. Doesn't anyone else understand what it is like to have no place to go?

Jack's Goal: A home and friends

Short-Term Tasks:

- Determine whether the lease violation (increased occupancy) puts Jack at immediate risk. Review the tenancy laws and educate him on rules for occupancy and timeframe for visitors.
- Work with landlord to establish a timeframe to fix the violation
- Review process and implications for voucher of getting someone added to the lease

Long-Term Tasks:

- Discuss what Jack's goals are in this particular relationship. Are he and the woman trying to establish or strengthen a romantic relationship by living together? What does he want in the long term?
- Identify options related to the goals that have been established. Weigh out positives and negatives of each option. Make a plan.
- Address his loneliness and loss of role as a leader in the camp. Offer options to continue serving others and holding a leadership role; explore a peer support role or volunteering.

Case Study: Criminal Activity

Phillip has been struggling. Engaged in an ongoing cycle of drug use and detox, and being in and out of treatment, he has been using more lately. His phone is out of service; he sold some of his furniture; and, on your last visit, he did not answer the door. Now the landlord tells you that people are dealing out of the apartment, and the landlord wants Phillip out. Phillip says he does not want to lose his housing.

Phillip's Goal: Keep his housing

Short-Term Tasks:

- Ensure that landlord has made tenant aware of allegations
- Assess risk; do not go to the apartment alone. Police escort may be necessary.
- When you meet, reinforce and use the requirements of the lease and the subsidy. Explain that, if proven, this is grounds for eviction.
- If Phillip is picked up on criminal charges, provide support, identify treatment options, and connect with a lawyer. Also, explore alternate or Veteran-specific courts and jail diversion treatment programs.

Long-Term Tasks:

- If not arrested, provide support, identify treatment options, identify path to alternate housing
- Reconnect Phillip to his long-term goals and dreams
- Consider project-based permanent supportive housing with more security

Case Study: Health and Safety: Hoarding

Howard has been homeless for a long time, but even while living in a shelter he maintained several storage spaces. He worked hard to sort his belongings to move into housing, but now everything is starting to pile up again. He is even finding furniture on the street and moving it into his apartment. The landlord is alarmed—he visited Howard in the apartment and found the rooms filled with furniture and newspapers. Food was spoiling on the tables and there was a terrible smell. Howard is worried. He called you to say that the landlord wants him out but he doesn't know why.

Howard's Goal: Stay in his home

Short-Term Tasks:

- Negotiate with landlord to establish a timeframe to fix the violation. Ensure the landlord notifies the tenant. If the landlord is not a good choice, use the subsidy administrator or a supervisor.

- Establish that Howard’s goal is to keep his apartment. Educate him on the expectations of tenancy and the requirements for keeping his housing subsidy.
- Assess Howard’s ability to sort the accumulated belongings, provide assistance if needed, and, if required, enlist adult protective services, heavy duty cleaners, or clinicians for psychiatric assessments

Long-Term Tasks:

- Establish regular visits by HUD-VASH worker and/or community agencies to monitor in future

Case Study: Utility in Arrears and Substance Use

Elliot has a service-connected disability. He has a serious back injury and has been on painkillers for some time. Elliot has tried physical therapy, acupuncture, and hypnosis as well as more conventional treatments. He has complained of pain since he first came into housing, but something has changed. He calls you to check in, but says he is too tired for a home visit. You finally do get to visit him and he seems dazed. He has no food in the refrigerator, and, during the visit, it becomes clear that he is behind on his electric bill. He reports that he rarely leaves the house. You suspect he has increased his pain medication, and that this is where his money is going.

Elliot’s Goal: Manage pain safely to maximize his ability to create the life he wants

Short-Term Tasks:

- Help Elliot address the utility bill. Work with him to negotiate a payment plan with the utility company. Educate him on the expectations of tenancy and the consequences of discontinued utilities.
- Offer assistance by making a plan to get food delivered by connecting Elliot with services such as Meals On Wheels, etc.

Long-Term Tasks:

- Re-establish goal of housing maintenance. While working together, assess Elliot’s ability to function and whether or not he is putting himself at risk.

- Address the back pain issues. Reconnect with treating physician, request pain consult. Offer alternatives to address pain issues.

Key Practices

- Enhance Veterans’ motivation
- Assess Veterans’ readiness to change and use motivational techniques consistent with Veterans’ stage of change
- Explain link between current activities and Veterans’ long term goals to help maintain motivation
- Discuss reasons for past housing loss; identify highest priority threats to housing stability
- Provide Veterans with education about expectations of tenancy
- Where needed, help Veterans create household budgets or connect them with financial literacy services
- Where needed, arrange representative payee and/or direct vendor arrangements to pay rent

Test Your Knowledge

Quick Check: Answer “true or false” to the following statements to check your knowledge about challenges to housing stability.

- 1) The Housing Authority should educate Veterans about maintaining a home.
- 2) Case Managers can help prevent housing instability by doing home visits weekly at first and at least monthly ongoing.
- 3) Gently raising awareness in a non-judgmental way of how behaviors interfere with personal goals can be an effective intervention.
- 4) Continuing to connect behavioral changes to maintaining housing may cause a Veteran to reject services.
- 5) Arranging for a representative payee provides a crutch for a Veteran that doesn’t allow him or her opportunity to take charge of his or her own housing stability.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) What are some key reasons and circumstances that a household's tenancy might be threatened?
- 2) If a Veteran fails to pay rent and instead has given money to a family member, what responses can

the Case Manager have to prevent loss of housing and help the Veteran make better decisions?

- 3) Review the case studies in this chapter with your team and talk through the short-term and long-term tasks you might implement.

Tools for Supervision and Training

What's in This Chapter?

Supervision in HUD-VASH requires an understanding of a multitude of disciplines and practices as well as team structures and training opportunities that can help you continue to improve your HUD-VASH program.

In this chapter, you will learn

- The purposes and how-to's of HUD-VASH supervision and training;
- How to set-up and manage team meetings, case conferences, and clinical consultation; and about
- Opportunities to work with Network Homeless Coordinators.

As a supervisor, this chapter will provide you with a set of tools from which to develop the structure and approach for your HUD-VASH team. In concert with many other chapters from this *Resource Guide*, you will gain a comprehensive understanding of the work of the VA in HUD-VASH and specific tools for leading its success.

Introduction

Good supervision and training are essential for Case Managers in their efforts to help Veterans remain housed and to achieve their other goals. The tools and forms introduced in previous sections of this manual can help supervisors to structure their individual and group work with staff as well as to identify needs that should inform the development of staff training programs.

Training and supervision should be mutually reinforcing and neither intervention alone is sufficient to ensure good outcomes. While it can be helpful to send staff to training, if the concepts are not reinforced and translated into specific practices that the worker is able to implement, the full value of the training will not be realized. At the same time, supervisors face many competing demands and supervision can often be the first thing that goes to the bottom of the list. Managers and administrators must reinforce that supervision is important and ensure that supervisors are trained and supported to find the time to provide it.

Purposes and Goals of Supervision

The primary purposes of supervision and training can be broadly conceptualized as follows:

- 1) To ensure that organizational, program and client goals are achieved through administrative oversight of tasks,
- 2) To provide education and information to staff that builds their skills and knowledge to perform their jobs more effectively and to develop professionally, and
- 3) To provide support to staff as they encounter obstacles and experience setbacks in their work, and assist them in setting goals for future performance and professional development.

Supervising staff in housing stabilization services delivery requires that supervisors understand the tasks involved in locating housing as well as the requirements and conditions of a Veteran's tenancy.

Assigning Caseloads

Supervisors should consider staff expertise and client needs when assigning cases. During the housing search and right after move-in, a Veteran and his or her family will likely need extra support as they transition from homelessness. Some clients/families will have chronic, serious issues that will present complicated clinical challenges for the long haul.

The CTI model advocates that workers have a mix of case assignments. As much as possible, they should be working with some clients in early stages of transition and some with more residential stability, as well as handling some higher- and some lower-need assignments. This provides staff with opportunities to see success as well as grapple with more complex needs.

Supervision and Training Tools

A variety of tools are available to supervise and train staff. The most common method is through individual meetings with Case Managers. Case conferences, which are a form of group supervision, allow staff to think and work together and provide an opportunity for them to learn from each other. Team meetings provide a vehicle to deal with administrative tasks efficiently, share resources, and identify ongoing program development needs as well as systems and resource issues that impact the service.

Clinical consultation from a psychiatrist, licensed clinical social worker, psychologist or other seasoned clinician can be an invaluable resource for case consultation and staff training. Many Veterans, particularly those who have been chronically homeless, present some of the most complicated clinical challenges workers will face.

Group trainings and conferences can be efficient ways to share information with larger groups of staff. However, as noted above, reinforcing concepts and skills learned in trainings on the job is a critical function of other supervisory activities.

Individual Supervisory Meetings

Weekly individual meetings with each Case Manager are recommended, but, at a minimum, meetings should be held bi-weekly. The primary purpose of this meeting is to review progress on service/housing stabilization plans with the Veterans on the worker's individual caseload. The supervisor can use the CTI Phase Tracking Form (on the next page) to see how the Veteran is moving through the phases and achieving goals. In order to ensure stability and prevent crises before they occur, each household should be discussed at least monthly in individual supervision or a case conference.

Individual supervision focuses on helping the Case Manager understand his or her role and to plan interventions with Veterans and their families. The supervisor helps staff decide how to link changes in behaviors to client goals and aspirations. For example, a Veteran may be more motivated to take medications as prescribed if the medication is linked to getting or keeping a job or something else that the Veteran has identified as important to him or her.

Finally, individual supervision focuses on the administrative aspects of the work, ensuring that Housing Stabilization Plans and Assessments are updated on schedule and that other documentation and contact requirements are met.

Phase Tracking

The CTI Phase Tracking Form on the next page is a useful tool for Case Managers and supervisors to see client progress, or lack thereof, and to focus supervision.

CTI Phase Tracking Form

CTI Worker Name:

Supervisor Name:

CTI worker: Take latest updated copy of form whenever you go into the field.

Supervisor: Keep form updated, make copies for staff, bring to all supervision meetings for reference during case review, remind CTI workers of upcoming transitions, and monitor whether CTI workers make their phase treatment plans on time.

Goal Areas: Identify the 3 primary areas of focus for each phase using the goal numbers below.

- Goals:**
- | | | |
|------------------|------------------------|---------------------------------------|
| 1. Housing | 2. Income | 3. Health/Mental Health Treatment |
| 4. Substance Use | 5. Family Intervention | 6. Independent Living Skills/Supports |

Veteran	Pre-Housing Date Enrolled	Pre-Housing Goals (from list above)			Phase I Start Date Housed	Goals (from list above)			Phase II Start Date	Goals (from list above)			Phase III Start Date	Goals (from list above)			Case Closed Date
<i>Joseph Small</i>	<i>1/6/09</i>	<i>1</i>	<i>2</i>	<i>4</i>	<i>4/17</i>	<i>1</i>	<i>2</i>	<i>4</i>	<i>7/21</i>	<i>1</i>	<i>4</i>	<i>5</i>	<i>10/16</i>	<i>1</i>	<i>4</i>	<i>5</i>	<i>1/28/10</i>
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Sample Case Manager Job Description for the Delivery of Housing Stabilization Services using Critical Time Intervention¹

DUTIES AND RESPONSIBILITIES:

The primary responsibility of the HUD-VASH Case Manager is to assist each Veteran and their families participating in the HUD-VASH program to access and maintain both housing and needed services and supports that will assist them to stabilize in their communities. The HUD-VASH program is committed to serving chronically homeless and vulnerable Veterans and each case manager is charged with increasing access to the program for this population.

As a member of the team, the HUD-VASH Case Manager will carry a caseload of approximately twenty-five to thirty five assigned Veterans and their families who have been identified as meeting the criteria for HUD-VASH services. HUD-VASH case management services will be guided by the tenets of Critical Time Intervention (CTI) as well as other evidence based practices and will include, but not be limited to, the following activities: engagement, building rapport, assessment, service and support referrals, housing access, and follow-up housing stabilization and retention services. Responsibilities will also include keeping accurate records as well as working as an advocate for the individuals on the caseload in order to obtain appropriate services, care and housing.

HUD-VASH Case Management

1) Establish ongoing relationships with chronically homeless, VASH-eligible Veterans, utilizing motivational interviewing techniques and proactive engagement strategies

- a. Maintain regular contact with identified Veterans and their families
- b. Identify housing preferences and barriers to access and retention
- c. Identify issues of concern/need and address as appropriate
- d. Discuss short and long-term goals with

individual, develop and document plan to meet them

- e. Begin the housing planning process with each Veteran

2) Establish eligibility for the HUD-VASH program

- a. Verify the Veteran's Status, eligibility for VA medical care, need for case management services
- b. Follow the process for referrals, evaluation, and admission to the HUD-VASH Program, ensuring that eligible Veterans and their families are placed into the program
- c. Continue to provide appropriate treatment and supportive services to the potential HUD-VASH Program participants, assisting the Veteran in the PHA issuance of the rental voucher process
- d. Provide housing search assistance to the HUD-VASH Participants with vouchers

3) Conduct assessment, referral; provide follow-up services to individuals in appropriate treatment, supportive and other programs both VA-based and in the community.

- a. Learn about the Veteran's (and family's, if applicable) treatment, housing and support history. Discuss what worked, what didn't, and why.
- b. Identify and prioritize needed services and target most appropriate options
- c. Assess barriers to housing stability and target interventions accordingly
- d. Develop a plan to access housing, services and supports. Actively involve the Veteran in the assessment and development of the housing plan.

4) Work with individual to reach identified goals emphasizing self-determination, responsibility and respect.

- a. Assist Veteran (family) with housing location, ID, benefits, income, employment, education, health, legal and other issues to support stable tenancy and life goals

¹Adapted from the Department of Veterans Affairs, VHA Handbook 1162.05. HUD-VASH Program. Washington, DC: 2009.

- b. Advocate for Veteran's (family's) needs as necessary within larger system of services and supports
- c. Arrange, coordinate care, and provide direct clinical services and support

5) Once appropriate placement is achieved, utilize the three-phase Critical Time Intervention model to work with Veteran (family) and service providers to maximize support, community integration, and housing stability.

- a. With the Veteran (family): Maintain close contact with Veteran throughout transition to housing, including visiting the new home, and assist the Veteran (family) in becoming familiar with the new community.
 - i. Provide direct services to the Veteran (family) while working to connect each with both VA and community resources
 - ii. Provide direct mental health and substance use counseling within the scope of the practice and role as case manager
 - iii. Meet regularly with landlords, PHAs and tenants to ensure a safe living environment and address any tenancy and/or subsidy issues
 - iv. Provide crisis prevention and management services as need to maintain the Veteran (and family) safely in the community
 - v. Monitor physical and mental health and substance use status and stability
 - vi. Regularly discuss changes in psychiatric symptoms and/ or triggers for substance use
 - vii. Provide access to treatment resources and encourage re-entry into treatment
 - viii. Work to improve life and tenancy skills by participating with Veterans in their new housing arrangements
 - ix. Provide education on life skills such as: credit, repair, financial literacy, shopping, and maintaining a household, safety and tenancy requirements

- x. Facilitate Veteran's (family's) participation in employment and training both within the VA and other community resources
- xi. Remain accessible and responsive to the Veteran and their families maintaining a focus on HUD-VASH plan
- xii. Discuss Veteran's concerns, fears, and frustrations, and work to resolve or alleviate while challenging the individual (family) to address these potential obstacles of his/her long-term goals
- xiii. Make intensive efforts to locate missing clients

- b. Work with the VAMC and Community providers and supports: carefully coordinate these linkages
 - i. Meet together with the Veteran (family) and providers to adjust the service plan. The plan is to be adjusted at 3 month intervals documenting progress towards greater independence and housing stability.
 - ii. Monitor linkages to ensure follow-through and success or challenges. Intervene, when necessary, and advocate on behalf of the Veteran (and family) to fill gaps in services.
 - iii. Arrange for or provide transportation for necessary appointments
 - iv. Educate the providers about the HUD-VASH Case Manager's role with the Veteran (family)
 - v. Share information with the providers and supports as appropriate respecting confidentiality
 - vi. Establish and encourage ongoing communication between landlords, PHA, VAMC, community providers, and supports
 - vii. Observe and test the housing stabilization service plan. Update accordingly.
 - viii. Be prepared to step-down the case management services as Veterans and their families are more able to use other resources and increase independence

- ix. Make a plan for decreased services or transfer to non-HUD-VASH subsidies not requiring Case Management Services

6) Document in a timely and accurate manner in the HUD-VASH file and the NEPEC system.

7) Develop a broad familiarity of available treatment and supports that may be available to Veterans and their families. Ensure that all of the HUD-VASH team has access to identified resources to support all Veterans participating in the HUD-VASH program.

- a. Visit behavioral health treatment sites both within the VA system and in the community and know how to access them
- b. Know the behavioral health services available for persons with various needs, i.e. crises, medical complications, substance abuse issues, chronic/low demand
- c. Attend ongoing training to learn new ideas in assisting persons with mental illness, substance abuse issues, and co-occurring disorders
- d. Develop expertise in assisting Veterans with benefits, legal, employment and educational opportunities
- e. Establish expertise in working with families, both living together and apart

8) Follow all Veterans Administration policies and procedures to maintain professional standards of the HUD-VASH program, safety of staff and those we serve.

- a. Participate as a full team member
- b. Maintain strong relationships with community resources

9) Participate in staff meetings, case conferences and individual supervision.

- a. Consult with Supervisor and team on strategies for serving Veterans and their families

10) Maintain collaborative relationships with HUD-VASH team and VA staff, other service providers, and professional behavior toward the public.

Clinical Consultation

Ongoing support from a senior clinician is helpful with assessment and service and treatment planning. Many Veterans and their families have complicated lives that include substance use disorders, PTSD, depression and other mental health problems as well as medical conditions that require ongoing treatment, sometimes all at once. A senior clinician can consult with staff to ensure that the Veteran is getting coordinated care and provide advice on ongoing assessments and service planning.

The clinical consultant does not replace the case management supervisor; rather, this position supports and trains the team and may even provide some direct services in particularly difficult cases or when there are concerns about risk of suicide, violence, domestic violence, and/or child abuse. A clinical consultant may be assigned to the team part-time. This position can also assist in evaluating fidelity to the CTI model and assisting with ongoing program development.

Working with the Network Homeless Coordinators (NHC)

Each Network Homeless Coordinator (NHC) has VISN-level responsibility for oversight and monitoring of the HUD-VASH Programs in their VISN. The NHC is a resource for Case Managers and Supervisors.

According to the VHA Handbook for HUD-VASH, the NHC is responsible for

- Ensuring HUD-VASH Programs are monitored and evaluated as prescribed by established VA medical center policies;
- Reviewing North East Program Evaluation Center (NEPEC) results and other evaluation data (HUD-VASH Dashboard) and working with VA medical centers;

- Assisting HUD-VASH Case Managers to develop thresholds, clinical indicators, program monitors, and corrective actions, when necessary;
- Working with VA medical centers and HUD-VASH Case Managers, along with Quality and Performance Management staff, to include HUD-VASH Programs in risk management and reporting systems;
- Reviewing HUD-VASH Programs' critical incidents and initiating appropriate investigation and follow-up activities in collaboration with the respective medical center;
- Providing support, guidance, and advice to HUD-VASH Case Managers through regular communications, including site visits, to facilitate mentoring, problem solving, and compliance."¹¹

housing stability. Priorities for case review include households that have

- Rent arrears,
- Poor living conditions,
- Multiple crises,
- Problems with nuisance or criminal behavior, and/or
- Children with poor school attendance.

Outline for Case Conference Presentation

- I. Current challenges and reason case was selected for presentation
- II. Relevant information from the Housing Stability and Barriers Assessment
- III. Efforts made to address the challenges
- IV. Questions and discussion with the group
- V. Resolution on next steps

Case Conferences

The CTI approach strongly recommends the use of weekly case conferences in which the whole team meets and reviews cases that have been pre-selected through weekly supervision or ongoing supervisory monitoring. The purpose of the case conference is to improve staff knowledge and skills in helping Veterans access and maintain housing and achieve their goals. The focus is on assessment, service planning and developing creative case management interventions. Case conferences are generally 1 – 1.5 hours in length, allowing time for discussion of 2-4 cases. Preferably, the clinical consultant is at the case conferencing meetings. NHC's can also be invited to case conferences, to consult especially on cases where there have been critical incidents.

Cases with multiple or unusual obstacles to housing stability—both successful and unsuccessful—are presented by the relevant Case Manager. The whole team engages in problem-solving and/or identifying best practices and lessons learned through the process.

It can be useful to select cases for review based on commonality or diversity across barriers to

Team Meetings

Team meetings are different from case conferences in that they focus more on the administrative and systemic issues that arise in the work. In these meetings, the team can look at overall progress and identify themes and common barriers in the work. Team meetings also provide an opportunity for staff to share resources and information with the rest of the team, identify best practices and plan how to respond to challenges that cut across case loads. Ongoing program and resource development is also a function of these meetings.

At team meetings, it is useful for the supervisor to review the whole team's caseload with the total number of people at each Phase of CTI. It is also useful to review clients who are in crisis, especially to identify needs for clinical consultations and brief team members who may be needed to intervene or provide back up. Finally, debriefing critical incidents can be an agenda item for team meetings.

These meetings also have a support and team-building function. They can be great forums to recognize staff successes, build cohesion, and

reinforce shared aims and values. Finally, team meetings can be used to identify staff training needs and resources for professional development.

Learning through Observation: Modeling and Role-Plays

A very effective way for staff to learn new skills and approaches is to observe other staff in interactions with clients. Supervisors can meet with workers together with Veterans (and their families) to model various skills and interventions. This is especially helpful for new workers or staff who are new to providing services in the home or in the community (off VAMC grounds).

Using role-plays where the staff person takes the client role and the supervisor assumes the Case Manager role can be useful to help prepare for meetings with the client, especially when a challenging meeting is anticipated. After the role play, the staff person and the supervisor would review the strategies used by the supervisor during the role-play and reflect on how that affected the client's reactions.

Group Trainings and In-services

All staff will need to be oriented to the HUD-VASH case management model as well as the voucher issue processes at the local Housing Authority. Additionally, trainings are recommended in the following areas, as they address critical skills and areas of expertise HUD-VASH Case Managers need to be effective in their practice:

- Housing location strategies
- Working with landlords to support the Veteran's housing stability
- Critical Time Intervention
- Stages of Change
- Motivational Interviewing
- Housing First and Rapid Re-housing
- Trauma-informed services
- Accessing benefits and entitlements

- Conducting risk and suicide assessments
- Child abuse and neglect – especially the requirements for mandated reporters in your State
- Trainings by the Network Homeless Coordinators on local initiatives, coordinating with the local homeless Continuum of Care system, and improving program performance

Key Practices

- Assign Case Managers a mixed caseload with cases at different stages and of varying complexity
- Conduct individual supervision with each Case Manager weekly or biweekly, reviewing housing plans, assessments, and contacts for each case at least monthly
- Hold weekly case conferences to discuss 2 to 4 preselected cases and invite any clinical consultants
- Hold regular team meetings to address administrative or systemic issues
- Use modeling and role-plays to improve Case Managers Skills'
- Provide group trainings and in-services on critical topics to build Case Managers' knowledge and skills

Test Your Knowledge!

Quick Check: Answer "true or false" to the following statements to check your knowledge about HUD-VASH supervision.

- 1) Case conferences are a form of group supervision in which the team discusses specific cases whether they are working on them or not.
- 2) Weekly meetings with each Case Manager are recommended.
- 3) HUD-VASH caseloads never exceed a 1:10 staff to client ratio.

- 4) Adding clinical consultation from a psychiatrist or other clinician to the team can complicate the group dynamic and should be avoided when possible.
- 5) The Network Homeless Coordinators are resources for Case Managers and Supervisors.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) What are some of the purposes of supervision and training?
 - 2) What qualifications are you seeking in a Case Manager? What should be in the job description for this role?
- 3) What kinds of things do you anticipate reviewing with Case Managers in individual weekly meetings? How do these topics differ from those you might have on an agenda for a team meeting?
 - 4) What responsibilities do Network Homeless Coordinators have that can be an enhancement to your team?
 - 5) Providing group trainings and in-services is critical to building Case Manager knowledge and skills. What topics should be covered in trainings?

Creating a Full System of Response to End Homelessness among Veterans

The Big Picture: A System of Response to Prevent and End Homelessness

In Part 1, we took a close look at many aspects of HUD-VASH: eligibility, targeting, administrative processes, and housing stability strategies. Before diving into Part 2, which focuses on prevention and clinical issues, it is useful to step back and examine how VASH fits within a larger, coordinated and targeted set of services and housing interventions that the VA and its community-based partners are developing to prevent and end homelessness among Veterans. We refer to this larger set of interventions as a 'system of response.'

What is a System of Response?

A system of response is a fully coordinated and comprehensive approach to ending and preventing homelessness at the local or community level. A system of response is meant to replace the ad hoc, uncoordinated, and haphazard services that actually perpetuate, rather than end, homelessness. Unfortunately, this stopgap service administration often characterizes much of what is available in communities for Veterans experiencing or facing homelessness. In contrast, a functioning system of response actively seeks and identifies Veterans experiencing and facing homelessness. As these Veterans are incorporated into the system, they are provided with immediate and appropriate assistance. These interventions may help them avoid housing crises or enable them to exit homelessness permanently.

There are three essential components of a community system of response:

- 1) Coordinated systems of **outreach and in-reach** that make it possible to identify Veterans experiencing, or at-risk for, homelessness across a wide variety of settings and institutions
- 2) A full **range of housing options, service interventions, and differentiated responses** that is tailorable to Veterans experiencing different levels and forms of homelessness (chronic/episodic, short-term, new entry, at-risk due to institutional discharge, and at-risk due to housing loss)
- 3) Coordinated **methods for matching individuals to the appropriate interventions** based on urgency of homelessness/housing crisis and level of needs (e.g., see chart of Housing and Service Needs in Chapter 3)

A SYSTEM OF RESPONSE IS...

Coordinated. It includes systems of outreach and in-reach to identify Veterans experiencing, or at risk for, homelessness across a wide variety of settings and institutions.

Resource rich. It includes a full range of services for Veterans experiencing different levels and forms of homelessness.

Systematic yet tailorable. Response options are linked to a coordinated methodology for matching individuals to appropriate interventions based on urgency of homelessness/housing crisis and level of needs.

Coordinated Outreach/In-Reach to Identify Homeless Veterans

Veterans experiencing homelessness, or who are at risk for homelessness, are less likely to already be engaged with VA services than their stably-housed counterparts. Therefore, community systems of response must have coordinated and comprehensive approaches to identifying homeless and at-risk Veterans across a wide variety of settings. (see Figure 1). These settings include

- Traditional homeless assistance settings such as homeless shelters, streets, drop-in centers, food pantries;
- Institutional settings like hospitals, detox facilities, substance abuse treatment programs, courts, jails and prisons; and
- The community, particularly neighborhoods characterized by high rates of poverty, housing loss and evictions.

Different Patterns of Homelessness Require Differentiated Responses

A system of response, with its full range of housing options and support services, provides the breadth and depth of resources necessary to tailor interventions for differing patterns of homelessness. Matching clients with appropriate support programs

requires a fundamental understanding of the scope and nature of their experiences with homelessness, which are often categorized into three types: transitional, episodic, and chronic homelessness.

Transitional homelessness usually occurs once, for a short period of time. Exits from transitional homelessness usually require minimal assistance. However, this does represent a potentially preventable service failure for a vulnerable client. Transitional homelessness is, then, most easily addressed by engaging at-risk individuals with proactive service delivery.

Episodic homelessness is characterized by multiple or repeated periods of housing instability. Episodically homeless Veterans are likely to also be involved in other systems with set entry or release periods, such as inpatient psychiatric or treatment programs, the criminal justice system, or limited-stay housing shelters. The Veteran who is cyclically or episodically homeless lacks either the skills or resources to create or execute a long-term solution on his or her own, or any such plans are interrupted by crisis or an immediate short-term housing opportunity.

Chronic homelessness is often described as being semi-permanent. Veterans who are chronically homeless have been without fixed or regular shelter for a prolonged period of time and may have become resigned to homelessness as a lifestyle or routine.

PATTERN	CHARACTERISTICS	STRATEGY
Transitionally Homeless	Experience homelessness once, only for a short period of time, and leave on their own with little or no assistance	➤ Prevent entry into homelessness
Episodically Homeless	Multiple, repeated periods of homelessness. Characterized by intense periods of involvement with public service systems (jails, hospitals, other crisis services settings)	<ul style="list-style-type: none"> ➤ Rapid re-housing ➤ Transitional housing ➤ Permanent supportive housing
Chronically Homeless	Homelessness is a long-term or semi-permanent state. Unable or unwilling to exit homelessness without intervention.	➤ Permanent supportive housing

Full Range of Housing and Service Interventions

Veterans who are experiencing, or who are at risk for, homelessness need different types and levels of housing assistance and supportive services to avoid or exit homelessness permanently. A complete community system of response for ending homelessness among Veterans must address a comprehensive range of needs. Thus, it requires a full spectrum of proven housing and services interventions. These include

- **Permanent supportive housing (e.g., HUD-VASH).** Permanent supportive housing is comprised of full subsidies for permanent housing that are linked to wrap-around case management services. Permanent supportive housing is designed for chronically homeless and high-needs Veterans, especially those with complex behavioral health issues, co-occurring mental health and substance use disorders, and/or physical disabilities. Communities need not one, but several types, of permanent supportive housing options in order to meet the needs of eligible Veterans. This may include both single-site and scattered-site housing, models of care that focus on Housing First, programs that incorporate jail diversion, etc.
- **Critical Time Intervention (CTI).** CTI is a model of fully-subsidized permanent housing in which the housing voucher is linked to time-limited, phased case management services designed to help homeless Veterans with less-disabling mental health conditions to build and navigate a services network on their own.
- **Transitional Housing.** Short-term (less than 2 years) residential programs with on-site therapeutic, recovery-oriented, or self-help services can help Veterans gradually develop the skills they need to live independently.
- **Rapid Re-housing.** When a Veteran and his or her family has just lost housing, financial assistance and services can be provided for quick relocation to safe, stable housing. In this model, clients are also provided with transitional supports to help them retain housing.

- **Homelessness Prevention.** Short-term financial and case management assistance can be provided when Veterans and their families are in precarious housing settings, have been discharged from institutions or hospitalizations to a changed housing situation, etc. Prevention itself involves services along the full spectrum of supports, including connecting with estranged family members, relocation to more stable housing, behavioral health interventions, etc.
- **Patient-Centered Health Homes.** In this model of comprehensive and coordinated health care, primary health/medical, behavioral health, and other supportive services are combined for Veterans with chronic and complex health conditions who, if not provided with these comprehensive services, may face homelessness in the future.
- **Standard VA Services and Benefits.** The standard set of benefits and quality medical services provided by the VA are the first line of defense against Veteran homelessness.

Matching Individuals and Families to Appropriate Interventions

The final component of a community system of response involves tools and methods for matching Veterans to appropriate levels of need. For instance, HUD-VASH supportive housing is best suited for high-need, chronically homeless Veterans who need the long-term, low-demand support and assistance that this model provides. Transitional housing may work well for individuals who are able to overcome personal barriers and become employable, but not for those who have chronic mental health challenges. If communities target interventions to the wrong levels of need, they run the risks of having less positive outcomes and wasting scarce resources. Figure 3 presents ways these interventions “map” to different levels of housing and service needs and outlines how to match individuals to appropriate interventions.

FIGURE 1. OUTREACH / IN-REACH TO ENGAGE VETERANS EXPERIENCING OR AT-RISK OF HOMELESSNESS

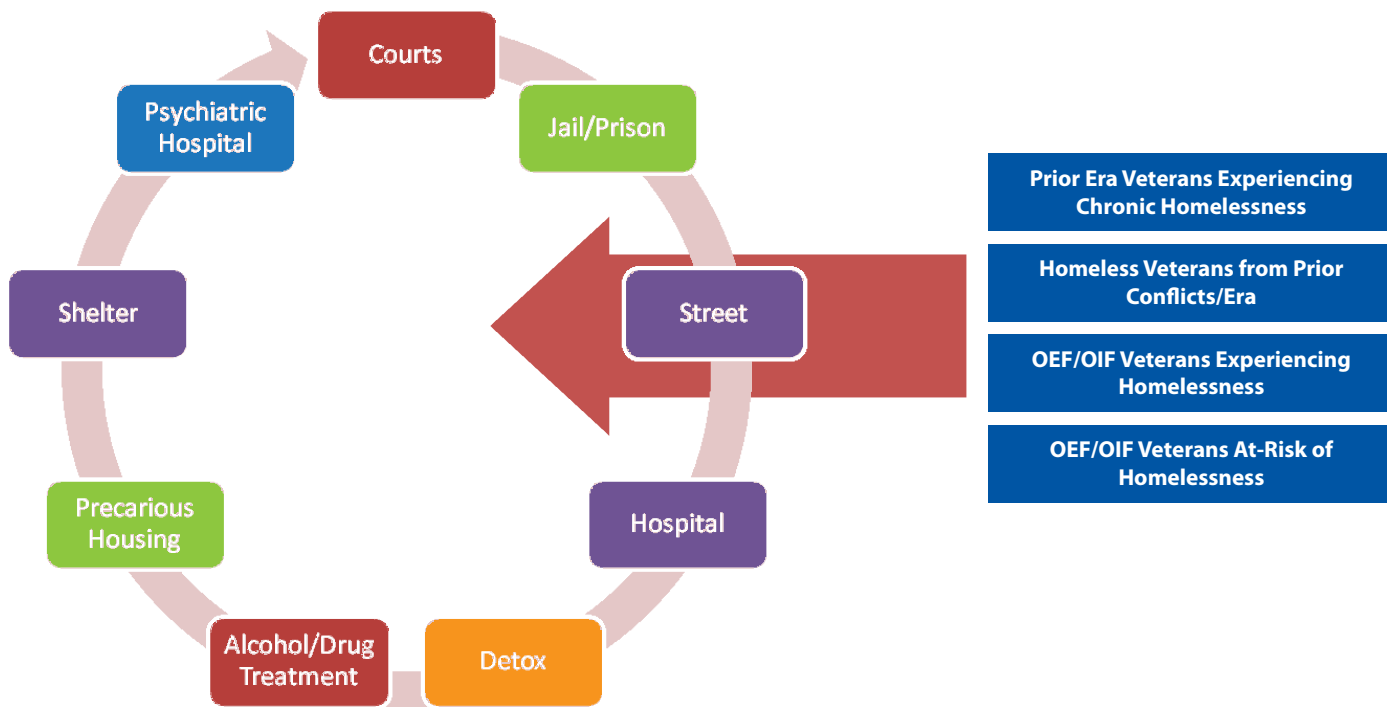


FIGURE 2. THE FULL RANGE OF INTERVENTIONS FOR ENDING AND PREVENTING HOMELESSNESS AMONG VETERANS

FEDERAL POLICY			Supportive Services for Veteran Families		Grant and per diem Program	HUD-VASH
	HOUSING SERVICES AND MODELS	Standard VA Services and Benefits	Patient-Centered Health Home	Homeless Prevention	Rapid Re-Housing	Temporary Supportive Housing
KEY PRACTICES	<p>Timely approvals of applications for VA benefits and services</p> <p>High-quality and professional services</p> <p>Identification of housing and services needs and possible referral to other services</p>	<p>Coordinated, wrap-around holistic health model including primary and behavioral health services and other social services supports</p>	<p>Assistance with eviction prevention or prevention of housing loss through short-term cash assistance, legal assistance, and short-term service supports</p>	<p>Rapid placement into housing through short-term cash assistance</p> <p>Very short-term service supports to help ensure transition to housing</p>	<p>Short-term (<2 years) residential model</p> <p>Services emphasizing self-help, substance use counseling, mental health counseling, and employment services</p> <p>Peer supports</p>	<p>Single-site and scattered-site models</p> <p>Housing First</p> <p>Long-term high-touch, voluntary intensive case management services</p> <p>Motivational interviewing and other EBPs</p> <p>Eviction prevention</p> <p>Rehabilitative services</p> <p>Peer supports</p>

FIGURE 3. MATCHING HOUSING NEEDS AND SERVICES NEEDS WITH APPROPRIATE INTERVENTIONS

Targeting Veterans for HUD-VASH vs. other VA programs should involve a consideration of housing needs and service needs as two separate but interrelated domains		HOUSING NEEDS		
		LOW	MODERATE	HIGH
		Veteran is currently and stably housed (rents or owns home or resides with family members), though may have occasional problems paying housing costs	Veteran is currently housed at imminent risk of housing loss due to eviction, has had history of housing crises/homelessness, or is housed in a temporary setting	Veteran is currently homeless and has had history of housing instability and homelessness
SERVICE NEEDS	LOW Veteran is able-bodied, connected to workforce, and few barriers to employment, self-sufficiency, and activities of daily living	Standard VA Services/Benefits	Supportive Services for Veteran Families	Supportive Services for Veteran Families
	MODERATE Veteran has some barriers to employment, self-sufficiency, or activities of daily living, which can be overcome or attenuated through services and treatment	VA treatment services	Supportive Services for Veteran Families or Grant and Per Diem	Supportive Services for Veteran Families or Grant and Per Diem
	HIGH Veteran has multiple and complex barriers to employment, self-sufficiency, and activities of daily living, such that services are needed on an ongoing basis	VA Patient-Centered Health Home	HUD-VASH	HUD-VASH

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) What are some examples of universal prevention activities?
- 2) Which groups might benefit most from targeted prevention efforts?
- 3) What are some situations a Veteran may face that would be considered “at immediate risk” for homelessness?
- 4) What resources are available for formerly incarcerated Veterans? Why is it important to have programs targeted for this population?
- 5) Surveys of individuals experiencing homelessness show an inverse relationship between homeless status and educational attainment. What VA education and benefits resources does your team need to know about to help Veterans who are at risk of homelessness?

Homelessness Prevention

What's in This Chapter?

The concepts of housing stabilization and homelessness prevention share many of the same techniques and case management practices. In this chapter, you will explore how these concepts work together, and you will become familiar with how each of these relates to specific nature of Veteran homelessness and to its unique solutions.

After reading this chapter, you will also be familiar with prevention programs and activities that you can use to help Veterans who are at risk for homelessness.

The Need for Veteran-specific Homeless Prevention Services

The need for Veteran-specific homelessness prevention services is underscored by a body of evidence with several main findings:

- One in ten low-income Veterans experiences homelessness each year (HUD, 2009),
- An estimated 2.3 million Veteran households in rental housing had low (defined as less than 80 percent of area median income [AMI]) incomes in 2005, and
- Of these 2.3 million tenant Veteran households with low incomes, 1.3 million of these households had very low incomes (less than 50 percent of AMI), placing them at high risk for housing instability (U.S. Government Accountability Office [GAO], 2007).

To address this, the U.S. Congress authorized two VA-led homelessness prevention programs—the Veterans' Homelessness Prevention Demonstration (VHPD) Program, and the Supportive Services for Veteran Families (SSVF) Program.

Conceptual Framework for Preventing Homelessness

VA, together with other federal, state, and community agencies, and along with the private sector, provides a diverse array of homelessness prevention services. These often include economic assistance for those in financial need; medical, psychiatric, and substance abuse care; housing programs; and employment, legal, and other services to help vulnerable Veterans. These programs and services are often referred to as *universal prevention activities*.

Prevention, or shutting the “front door” to homelessness, is widely recognized as a necessary component of any strategy to end homelessness (National Alliance to End Homelessness, 2000). However, the difficulties inherent in implementing effective prevention initiatives (Shinn, Baumohl, & Hopper, 2001) keep programs focused on accommodating those who have already lost their housing. Furthermore, even at maximum effectiveness, no program can prevent all homelessness. However, when a prevention-oriented policy framework is cast aside, the result may be the institutionalization of homelessness.

So stated Lindblom (1991) nearly 20 years ago. As explained by Burt and colleagues (2005, p. iv),

“To close the front door of entry into homelessness, the central challenge of prevention is targeting our efforts toward those people that will become homeless without the intervention. Providing prevention assistance to people who would not otherwise become homeless is an inefficient use of limited homelessness dollars.”

Stressing the use of proven interventions in the manner that is most effective, this model uses a continuum of housing instability to explain which

evidence-based interventions are most appropriate at various stages of progress. To ensure that prevention activities are both efficient and effective, resources should be directed toward three levels of prevention: primary, secondary, and tertiary.

Primary prevention activities are targeted at households who are at risk of homelessness, but when they are still in their current-housed-situation. By targeting at-risk individuals or Veteran-led households before they actually become unsheltered, new cases of homelessness can be prevented.

Secondary prevention activities assist those who are imminently homeless by quickly addressing the household's housing instability. Secondary prevention techniques are aimed at Veterans or Veteran-led households, especially during exits from inpatient or residential treatment services, other institutions, or temporary housing. Shelter diversion might also be applied to families or individuals who present either to the VA or to local continuum of care providers for emergency shelter.

Tertiary prevention activities reduce the impact of a household's existing housing instability and create opportunities for stable housing. Tertiary prevention practices focus on the currently homeless Veteran or the Veteran who receives housing and other supports through VA or from other community-based providers. These households may require a more intense level of intervention to access and maintain stable housing, and may require primary prevention interventions upon housing location.

Although this chapter focuses on primary and secondary prevention interventions, universal prevention activities, such as assisting with receipt of entitlements, play an important role in creating a service plan for at-risk Veterans. For such programs, The National Resource Directory is a valuable resource: www.nationalresourcedirectory.gov.

Targeting Veterans for Homelessness Prevention Interventions

Identifying Veterans in need of targeted interventions is a fundamental task for homelessness prevention efforts. Groups who could benefit

most from such focused prevention efforts include personnel returning from OEF/OIF; Veterans in inpatient settings; Veterans who are separating from a military service involuntarily due to physical or emotional trauma; Veterans receiving substance abuse and mental health treatment; Veterans living in the community who are receiving non-VA services; and Veterans in transition from acute or residential care to outpatient services.

An essential aspect of VA's targeting efforts involves the development and maintenance of ties between VA and the community. Stronger community relations, and collaboration with community-based homeless programs, significantly improves coordination of care. These same approaches may also improve ability to identify at-risk Veterans who present for services at community programs (McGuire, Rosenheck, & Burnette, 2002; Rosenheck, Resnick, & Morrissey, 2003).

VA-led primary prevention centers around Veterans for whom homelessness is considered an immediate risk. Interventions include provision of short-term assistance, such as referral to VA services; resolution of issues with family members or others involved with the current housing instability; short-term rent, mortgage, and utility assistance; and/or tenant-landlord mediation. These interventions will enable a large number of households to maintain their housing stability with time-limited assistance in an efficient and cost-effective manner (Culhane & Metraux, 2008).

Under VA's definition, for a Veteran and accompanying dependents to be considered "at immediate risk" of becoming homeless, they must be living at or below fifty percent of the AMI. They must also meet at least one or more of the following criteria:

- **Imminent loss of housing**, occurring when the household is (a) facing immediate housing loss and lacking the resources and support networks needed to find other housing; (b) facing eviction within 14 days; (c) living in a hotel or motel and lacking the resources to stay for more than 14 days; (d) living doubled-up and needing to leave within 14 days; and (e) living in housing that has been condemned or is in foreclosure. The Homeless Emergency Assistance and Rapid

Transition to Housing (HEARTH) Act, signed in May 2009, has expanded HUD's definition of homelessness to include these imminent risk conditions.

- **History of housing instability**, including (a) lacking a history of living independently on a consistent basis; (b) having experienced persistent instability, which will continue because of disability, health or mental health problems; addiction, abuse, or multiple barriers to employment; and (c) having recently had a traumatic event has resulted housing instability.
- **Imminent transition related to program or institutional discharge or domestic violence situation**, including (a) fleeing or attempting to flee domestic violence, without the resources to achieve housing stability; (b) leaving an institution (or engaged with courts), without a plan or the means to achieve stable housing; and (c) having completed a transitional housing or residential rehabilitation program, but needing time-limited supportive services to prevent a return to homelessness.

Secondary prevention strategies target very low-income Veterans, and their families, after they have become homeless. Interventions among this group stress rapid re-housing, diversion from a shelter, etc., and actively work towards resolving conflicts that have exacerbated a fragile situation. Secondary prevention involves working with landlords, family members, employers, etc., with the goal of returning people to prior housing arrangements—where they will also receive support services—whenever possible. When return to a prior housing arrangement is not possible due to personal safety or other issues, rapid re-housing efforts will be initiated, including short-term housing subsidies; rent, mortgage, and utility assistance; mediation or negotiation with landlords, including lease co-signing or security deposit arrangements; avoiding school truancy and working with school systems if relocated, etc. Case management and financial assistance will be used as a bridge to help Veterans move into and establish residence in affordable permanent housing. When necessary, these services may also be used to link eligible Veterans and their families into other subsidized supportive housing programs, such as HUD-VASH.

Both primary and secondary prevention strategies require a thorough assessment of family needs, including particular attention to a sustainability plan, as rapid re-housing and prevention interventions are inherently short-term. Planning must address long-term needs underlying current housing instability so that the precipitating crisis does not recur.

VA Program Options Available to Case Managers

The VA has embarked on several prevention-focused initiatives designed to specifically augment primary and secondary prevention strategies.

Supportive Services for Veteran Families (SSVF)

Public Law 110-387 authorized VA to develop the Supportive Services for Veteran Families (SSVF) Program. Under the SSVF Program, VA awards grants to private non-profit organizations and consumer cooperatives that provide supportive services to very low-income Veteran families residing in, or transitioning to, permanent housing. Grantees are required to provide outreach, case management, and VA benefits assistance; they must also provide or coordinate efforts to obtain other entitlements (e.g., subsidies from state or local assistance programs) and to connect the Veteran family with community services. In addition, grantees have the option of providing temporary financial assistance to participants, which may include third party payment for rent, utility payments, security deposits, moving costs, child care, transportation subsidies, and emergency supplies.

The program's objective is housing stability via short-term, focused interventions. Consistent with the Housing First approach's core philosophy that permanent housing creates an environment in which other issues can be addressed, even if this occurs after exiting the program, SSVF promotes concrete steps toward stability. Individual SSVF case management plans should focus on meeting those needs.

SSVF supports both primary and secondary prevention activities; however, each grantee is required to spend the bulk of their funds on rapid

re-housing. This requirement is due in part to the challenges faced in effectively targeting at-risk – but housed – Veterans. As described earlier, the literature indicates that, although certain groups are at higher risk, existing targeting techniques cannot consistently identify who needs this service; that is, even the most astute case worker cannot determine who will become homeless without SSVF assistance. The National Center on Homelessness Among Veterans seeks to develop those targeting techniques through an analysis of SSVF outcomes and HUD's experience with the Homelessness Prevention and Rapid re-housing Program (HPRP).

Although not a mandatory component of the SSVF program, most grantees have elected to offer financial assistance. This financial assistance can take a variety of forms: rental assistance, utility payments, security deposits, moving costs, child care, transportation expenses, and emergency supplies. Consistent with the mission of SSVF as a focused, time-limited intervention, these payments are limited both in the amount of dollars that are available (a maximum of 30% of any grant) and the length of time that they can be offered to any family.

Whenever practical, grantees are encouraged to include co-payments by participants when financial assistance is provided. Sustainability plans are also an essential part of any plan that offers financial support. The most basic question that will need to be addressed is how the family will manage the expense (whether it is rent, the utilities, transportation, or child care) once the SSVF financial support is no longer available.

The objective of SSVF is to achieve housing stability over the shortest time possible. Part of the initial assessment will be determining if the family needs long-term, ongoing assistance and would be better served by a permanent supportive housing program, such as HUD-VASH.

Further information about SSVF can be found at www.va.gov/HOMELESS/SSVF.asp.

The National Call Center for Homeless Veterans (NCCHV)

The VA has established a National Call Center for Homeless Veterans hotline to ensure that homeless Veterans or Veterans at risk for homelessness have

free, 24/7 access to trained counselors. The hotline is intended to assist homeless Veterans and their families, VA Medical Centers, federal, state and local partners, community agencies, service providers, and others in the community. Veterans who are homeless, or who are facing a housing crisis, can seek assistance by calling (877)424-3838.

Criminal Justice Programs: Health Care for Re-Entry Veterans (HCRV) and Veterans Justice Outreach Initiative (VJO)

Approximately 9 percent of persons in jail or prisons in the United States are Veterans, amounting to well over 200,000 incarcerated Veterans nationwide (Greenberg & Rosenheck, 2008a; Greenberg & Rosenheck, 2008b; National GAINS Center, 2008; Noonan & Mumola, 2007). These numbers are likely to rise as Veterans return from Afghanistan and Iraq; this cohort of Veterans is at higher risk for incarceration due to high rates of substance use disorders, psychiatric disorders (e.g., trauma, PTSD, depression), and domestic violence. Most Veterans in jail are there for non-violent offenses (McGuire, 2007). However, Veterans face longer sentences than other arrestees for some types of offenses (Noonan & Mumola, 2007). At least 15-16 percent of inmates are homeless (Greenberg & Rosenheck, 2008; McNiel, Binder, & Robinson, 2005), including significant numbers of Veterans; when these incarcerated Veterans are released from custody, they are at particular risk for homelessness (McGuire, 2007).

Complicating service delivery to this group is the high proportion of sex offenders. According to the U.S. Department of Justice, 23 percent of the Veterans incarcerated in state facilities had committed a sexual offense, compared to 9 percent of non-Veterans. Sex offenders face a variety of barriers to housing, employment, and other benefits. A further challenge in serving this group is that 38 percent received other than honorable military discharges, potentially limiting their eligibility for VA services (Noonan & Mumola, 2007).

The Health Care for Re-entry Veterans (HCRV) Program is designed to address the community re-entry needs of incarcerated Veterans. HCRV's goals are to prevent homelessness; reduce the impact of medical, psychiatric, and substance abuse problems

upon community re-adjustment; and decrease the likelihood of re-incarceration. HCRV staff reach out to Veterans within six months of release from U.S. state and federal prisons. The goal of this clinical outreach is to connect Veterans with appropriate VA services, especially homeless prevention programs and mental health and substance use services. The VA's close cooperation with state Departments of Correction, and with the U.S. Departments of Justice (Bureau of Prisons, Bureau of Justice Statistics), Labor, and Health and Human Services (Office of Child Support Enforcement [OCSE]), have been critical for the successful implementation of the program.

The Veteran Justice Outreach (VJO) initiative seeks to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible justice-involved Veterans have timely access to VHA mental health and substance abuse services when clinically indicated and other VA services and benefits as appropriate.

Each VA medical center has been asked to designate a facility-based Veterans' Justice Outreach Specialist, responsible for direct outreach, assessment, and case management for justice-involved Veterans in local courts and jails, and liaison with local justice system partners. For a list of VJO contacts, check the VA's webpage at www.va.gov/HOMELESS/VJO.asp.

In addition, mainstream services can provide valuable aid. LawHelp, found at www.lawhelp.org, helps low and moderate income people find free legal aid programs in their communities, and answers to questions about their legal rights. Legal help for military members, Veterans, and their families can be found at <http://statesidelegal.org>.

Other Intervention Activities

Although this chapter focuses on primary and secondary prevention interventions, universal prevention activities such as entitlements play an important role in creating a service plan for at-risk Veterans. The National Resource Directory is a valuable resource for such programs at www.nationalresourcedirectory.gov.

Income Benefits

There are a broad range of mainstream income benefits available to assist Veterans and their family members. While typically considered universal prevention activities, these benefits also play an important role in primary and secondary prevention. As such, they often need to be a part of homelessness prevention and exit strategies.

The Veterans Benefits Administration (VBA) has 57 Homeless Veterans Outreach Coordinators (HVOC) nationwide at VBA Regional Offices. The HVOCs provide information and assistance on VA benefits and services, including eligibility criteria and procedures for filing compensation and/or pension claims. They provide outreach to homeless Veterans at shelters and stand downs, through state and local community partners, and in other areas where homeless Veterans may be located.

Securing Social Security benefits provides dependable assistance for those who are aged or disabled, yet this can often be a difficult and time-consuming process. According to the SSI/SSDI Outreach Access and Recovery (SOAR) initiative,

"Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are disability income benefits administered by the Social Security Administration (SSA) that also provide Medicaid and/or Medicare health insurance to individuals who are eligible. The application process for SSI/SSDI is complicated and difficult to navigate. Nationally, about 37 percent of individuals who apply for these benefits are approved on initial application and appeals take an average of two years to complete.

For people who are homeless or who are returning to the community from institutions (jails, prisons or hospitals), access to these programs can be extremely challenging. Approval on initial application for people who are homeless and who have no one to assist them is only about 10-15 percent. For those who have a mental illness, substance use issues, or co-occurring disorders that impair cognition, the application process is even more difficult – yet accessing these benefits is often a critical first step in recovery."

To find contacts for local SOAR initiatives, check their website at <http://www.prainc.com/SOAR/>

Employment, Vocational, and Educational Rehabilitation

Shaheen and Rio (2007, p. 341) also emphasize the importance of facilitating employment opportunities; they point out that helping locate employment “is an unrecognized and underutilized practice for preventing and ending homelessness.” Although Veterans who are homeless, or at risk for homelessness, often face a variety of personal, programmatic, and systemic reasons that may prevent them from working, employment has been found to be key to both residential stability and to recovery of mental health among people with SMI.

The VA’s Compensated Work Therapy (CWT) program provides vocational assistance, job development, job placement, and on-going supports to improve employment outcomes among homeless Veterans. Vocational Rehabilitation Specialists (VRS) are integrated into Health Care for Homeless Veterans (HCHV), Grant and Per Diem (GPD), HUD-VASH, Domiciliary Care for Homeless Veterans (DCHV), Healthcare for Re-Entry Veterans (HCRV), and the Veterans Justice Outreach Initiative (VJO) treatment teams for the purpose of providing community-based vocational and employment services. Vocational and employment services for homeless Veterans are based on the principles of rapid engagement, customized job development, and competitive community placement, and are coupled with on-going supports for employment maintenance.

There is also a clear link between educational engagement and residential stability. Surveys of individuals experiencing homelessness show an inverse relationship between homeless status and educational attainment. The link between educational attainment and later income, well established for the civilian population, is also consistent for people with SMI. Successful educational engagement contributes to greater community integration and participation. The support of Veterans’ education goals has long been a priority for VA, going back to the original G.I. Bill.

This commitment was strengthened by the Post-9/11 Veteran’s Educational Assistance Act of 2009, which authorized financial support for education and housing. Its benefits include tuition and fees, a monthly housing allowance, and an annual stipend for books and supplies to Veterans with at least 90 days of aggregate service on or after September 11, 2001, and honorable discharge.

However, Veterans who are homeless and who have SMI may have difficulty taking advantage of their G.I. Bill benefits. Studies show that these Veterans need special assistance to navigate the process of receiving benefits, enrolling in school, handling their symptoms, finding housing on campus, and dealing with other educational challenges. Such assistance can be found in the recovery-based programs of supported education services. Like supported employment, supported education is implemented in natural community settings (community colleges, adult education programs), the support is not time-limited, clinical and vocational services are integrated, and goals are driven by the person’s choice.

When Veterans with psychiatric and other disabilities choose to pursue an educational goal, supported education can provide the assistance necessary to enter and succeed in community-based educational programs at secondary or postsecondary levels. The goals of supported education include improving a Veteran’s literacy, study skills, and time management skills; supporting the Veteran as he or she navigates the educational environment; helping with applications and financial assistance; and improving attitude and motivation (Collins, Bybee, & Mowbray, 1998). Any comprehensive approach to homelessness prevention will include a supported education component.

Discharge Planning

Effective discharge planning from institutions of care (e.g., criminal justice system, inpatient psychiatric and substance abuse facilities) is a critical component of preventing homelessness (Backer, Howard, & Moran, 2007). One study found that homeless adults with chronic medical problems who were provided housing and case management

following a hospital discharge had fewer subsequent hospital stays and emergency visits compared to those receiving standard care (Sadowski, Kee, VanderWeele, & Buchanan, 2009). Veterans being discharged from VA care should be systematically screened for homelessness risk; Veterans who screen positive should be consistently referred to an array of preventive interventions matched to their level of need.

Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your knowledge about homelessness prevention.

- 1) One in 10 poor Veterans experience homelessness each year.
- 2) Unfortunately, there are currently no VA-funded homelessness prevention programs.
- 3) The central challenge of prevention is targeting efforts toward those people that will become homeless without the intervention.
- 4) One example of being “at immediate risk” of becoming homeless is losing a job.
- 5) The objective of the Supportive Services for Veteran Families (SSVF) program is to achieve stability through a short-term, focused intervention.
- 6) In SSVF, each grantee is required to spend the bulk of their funds on education and job training for “at-risk” Veterans.

- 7) The National Call Center for homeless Veterans is 24/7 hotline with access to trained counselors.
- 8) Approximately 9 percent of persons in jail or prisons in the United States are Veterans.
- 9) The Health Care for Re-entry Veterans (HCRV) program begins engagement with Veterans immediately upon exit from jail or prison.
- 10) Nationally, only about 37 percent of individuals who apply for social security benefits are approved on initial application and appeals take an average of two years to complete.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) What are some examples of universal prevention activities?
- 2) Which groups might benefit most from targeted prevention efforts?
- 3) What are some situations a Veteran may face that would be considered “at immediate risk” for homelessness?
- 4) What resources are available for formerly incarcerated Veterans? Why is it important to have programs targeted for this population?
- 5) Surveys of individuals experiencing homelessness show an inverse relationship between homeless status and educational attainment. What VA education and benefits resources does your team need to know about to help Veterans who are at risk of homelessness?

Treating Co-Occurring Disorders Within HUD-VASH: Evidence-Based Approaches

What's in This Chapter?

There is a high rate of co-occurring substance abuse and mental health disorders among Veterans enrolled in HUD-VASH. When the HUD-VASH team is familiar with strategies for engaging individuals with co-occurring disorders, it may help Veterans on their caseloads accomplish their recovery goals.

In this chapter, you will be presented with an overview of the evidence-based practices for treating mental illness, substance abuse, and co-occurring disorders, including

- Motivational Enhancement Therapy,
- Relapse Prevention,
- Twelve-Step Facilitation,
- Cognitive-Behavioral Therapy,
- Social Skills Training, and
- Assertive Community Treatment.

After reading this chapter, you will have a basic understanding of the evidence-based approaches to treatment for people with co-occurring disorders.

Introduction

As a HUD-VASH Case Manager, it is highly likely that you will encounter Veterans whose transition from homelessness is further complicated by mental health and/or substance use disorders. In fact, recent data from the HUD-VASH program suggests that 64% of Veterans who apply to the program suffer from alcohol abuse or dependence, and that over two thirds have at least one psychiatric diagnosis (O'Connell, Kaspro, & Rosenheck, 2010). As the ability to maintain housing is related to successful recovery from mental health and

substance use disorders, and as there is a high rate of co-occurring substance abuse and mental illness (COD) among Veterans enrolled in the HUD-VASH program, you may find it helpful to be familiar with the behavioral treatment approaches that have consistently demonstrated their effectiveness in helping people with mental illness and substance abuse accomplish their recovery goals. Such services are referred to as **Evidence-Based Practices** (SAMHSA, 2010). For the past 30 years, addictions researchers and mental health treatment providers have been developing and testing various therapeutic approaches and clinical interventions to better assist individuals suffering from mental illness, substance abuse, or COD. In this section, we will review the evidence-based practices that have been found to be most effective in treating this population.

Mental illness and substance abuse are commonly observed among the homeless population and have been recognized as important contributing factors to chronic homelessness, especially when these conditions co-occur (North et al, 1996). According to national data, approximately 45% of homeless Veterans suffer from a mental illness and (with considerable overlap) more than 70% suffer from alcohol or drug problems (VA, 2010). The most commonly observed mental health problems include mood disorders, PTSD, and schizophrenia, while the most common substances of abuse include nicotine, alcohol, marijuana, cocaine, and heroin (Mares & Rosenheck, 2006). Furthermore, many Veterans are polysubstance users, meaning that they use cocaine and/or other drugs, drink alcohol, and smoke cigarettes concurrently. Furthermore, approximately half of all individuals with Serious Mental Illnesses (SMI), such as schizophrenia and bipolar disorder, have also been diagnosed with

a lifetime substance use disorder; of these, 30% also meet the diagnostic criteria for a current substance use disorder (Regier, et al, 1990; Essock, et al, 2006). In a survey conducted by O’Toole and colleagues (2003), both homeless Veterans and non-Veterans had high rates of substance abuse; however, homeless Veterans were significantly more likely to have a chronic medical condition as well as two or more mental health conditions. Even so, when compared with homeless non-Veterans who participated in the survey, homeless Veterans were significantly less likely to access care from a community clinic.

Individuals who suffer from co-occurring disorders are also less likely to adhere to their prescribed treatment regimens (Dobscha, et al, 1999), and a recent study found that even relatively infrequent substance use (approximately 5-7 days of use per month) among individuals with mental health problems resulted in significantly greater treatment discontinuation (Smelson et al, 2006). Furthermore, another study found that patients who fail to connect to outpatient services after discharge from inpatient treatment are at a higher risk for recidivism (Dixon et al, 2009), and, unfortunately, estimates suggest that less than half of all discharged psychiatric patients ever successfully transition to outpatient care (Boyer, 1997; Nuttbrock, et al., 1997). Ultimately, this service fragmentation leads to increased “revolving-door” service usage. This stopgap service access, including cycling back and forth among shelters, using emergency and inpatient treatment services as primary care, and receiving little or no continuity for care post-discharge, contributes to poor treatment outcomes (Prince, 2006; Weiden et al, 2004). Furthermore, homeless Veterans, particularly those meeting the HUD definition of chronic homelessness, tend to use more costly acute services rather than outpatient and preventive treatment services. This is due, in large part, to disengagement in programs of continuing care (North & Smith, 1993; Padgett, Struening, & Andrews, 1990). Moreover, Veterans who have most recently experienced homelessness have been found to be less likely to use preventive services than non-homeless Veterans (McGuire & Rosenheck, 2005), ultimately leading to higher treatment costs (Rosenheck & Seibyl, 1998).

Sadly, the co-occurrence of mental health and substance use disorders often results in psychiatric symptom exacerbation, including an increased risk of suicide (Soyka, et al, 2001). Often, as substance abuse worsens, psychiatric symptoms worsen, which, in turn, causes an increased use of illicit substances in an attempt to cope with the intensity of heightened mental health symptoms. Additionally, chronic, heavy substance abuse also leads to legal problems; medical problems (including a greater risk for HIV) and acquisition of hepatitis and other infectious diseases; violence; housing instability; homelessness; and a greater burden on families, all of which contribute to higher treatment costs (Canton et al, 1994; Cuffel et al, 1994; Haywood et al, 1995; Rosenberg et al, 2001; Serper et al, 1995; Smelson et al 2002; Essock et al, 2006).

Given the high prevalence of mental illness, substance abuse, COD, and chronic medical conditions among homeless Veterans, as well as the high rates of service fragmentation in the treatment of homeless Veterans suffering from these illnesses, equipping HUD-VASH Case Managers with proven, evidence-based case management approaches, as well as the clinical tools to properly assess and treat mental health issues, is of the utmost importance. This is particularly true when working with Veterans in HUD-VASH who are suffering from SMI, as substance abuse is the most common psychiatric comorbidity among this population (Brunette, Mueser, & Drake, 2004; Adams, et al, 2007).

Evidence-Based Practices for Treating Mental Illness, Substance Abuse and Co-Occurring Disorders

As you work with Veterans enrolled in the HUD-VASH program who have the illnesses and disorders mentioned in the previous section, it will be helpful to have a general understanding of some of the evidence-based practices used to treat substance abuse and mental illness. In this section, we will briefly discuss some of these approaches. As an exhaustive description of all evidence-based practices used to treat mental illness and substance abuse is beyond the scope of this *Resource Guide*,

readers are strongly encouraged to visit the Substance Abuse and Mental Health Services Administration website www.samhsa.gov for further information.

MOTIVATIONAL ENHANCEMENT THERAPY (MET)

MET is a brief therapy designed to enhance motivation by helping clients resolve ambivalence about addressing and ultimately changing their problem behaviors (i.e., substance abuse). MET is derived from the Motivational Interviewing (MI) counseling approach developed by Drs. William Miller and Stephen Rollnick. MI is built on the idea that each client approaches treatment at a different—and fluid—level of readiness to change behaviors and/or address symptoms associated with mental illness. MET techniques are also designed to enhance counselor-client rapport and, for this reason, are particularly useful during initial sessions, when client ambivalence may be about treatment itself. The acronym “**OARS**” is used to identify the fundamental skills of MET: Open-ended questions, Affirming, Reflective listening, and Summarizing.

OARS

Open-ended questions

Open-ended questions are questions that are designed to encourage clients to elaborate about their thoughts and feelings and offer details about their situations. Open-ended questions, in other words, stand in opposition to questions that ask for a simple “yes” or “no” response. Open-ended questions should not sound judgmental. For example, unless the client has expressed concern about his/her drinking, the question, “What do you intend to do about your drinking?” will only elicit client resistance. On the other hand, open-ended questions are designed to help create internal motivation for change. Questions that sound judgmental will only cause clients to resist their treatment provider’s influence. More is said about how to deal with resistance below.

Affirming

Affirmations are a way of validating a client’s experiences or feelings, and also indicate that you are present and focused. However, it is important to note that this does not simply mean agreeing with everything he/she says. To be effective, affirmations need to be genuine. Examples of affirmative responses include, “*That must have been very hard for you*” or “*I really respect how hard you are struggling to overcome your drug problem.*” The inclusion of affirmations into your counseling style is essential during treatment and can be particularly helpful when working with Veterans who are more difficult to treat. Affirmations are useful for

- Reducing Veteran hopelessness and discouragement,
- Reducing *therapist* hopelessness and discouragement,
- Building rapport, and
- Reinforcing progress.

Reflective Listening

Reflective listening is considered to be one of the cornerstones of MET. Using reflective listening during sessions with your Veterans is a way for you to show that you are carefully listening. Reflective statements may be followed by questions like, “*Am I understanding correctly? Is there anything I’m not getting?*” to demonstrate the importance you place on accurately understanding what the Veteran you are working with is saying (i.e., his/her perspective) and to model an openness to the relationship. Reflective listening statements also tend to spontaneously elicit elaborations from the client without the need to directly ask a question. It is certainly appropriate to ask questions; however, Case Managers who mix questions with reflective statements will be more likely to create a better conversational flow, whereas those who only ask questions to advance a discussion may unwittingly create a passive Veteran (i.e., one who simply answers one question and then waits for the next). There are several different types of reflections:

- **Simple reflections**, which accurately mirror a Veteran's thoughts or feelings, and are further subdivided into four types:
 - 1) *Repetition*: a literal repetition of a Veteran's statement
 - 2) *Rephrasing*: restating the Veteran's statement in new words
 - 3) *Paraphrasing*: a more complex form of rephrasing that captures more than one thought or feeling
 - 4) *Continuing the paragraph*: inferring about an underlying thought, feeling or event;
- **Double-sided reflections**, in which the clinician restates both sides of an issue with which the Veteran is struggling; and
- **Amplified reflections**, which are slightly overstated in order to make a point.

Summarizing

The purpose of a summary is for you, as the Case Manager, to reflect general understanding. Essentially, this is reflecting on a larger scale. To use a metaphor, instead of reflecting on a particular tree, you are reflecting on an entire stand of trees (or even the forest). For example, after 10 minutes of discussion about a variety of interconnected topics (e.g., arguments with a landlord and co-workers, heavy alcohol use, PTSD symptoms), you may want to consider summarizing the discussion in order to help the Veteran make connections between them. Thus, you might say,

"We've talked about a few things in the past 10 minutes or so and what I'm hearing is that you have concerns about your relationships with some people at work and with your landlord. And that makes sense to me. These are important people in your life even if you might wish they weren't at this point. You also told me about your flashbacks in the past week and how upset they've been making you. I also know from what you just told me that you're feeling more like starting to drink again. If you did go back to drinking, how do you think it would affect these other problems?"

It is often helpful to

- Conclude a summary with an open-ended question designed to help make connections between the topics, and to
- Word questions in a non-judgmental way. An example of a more problematic wording of the question is, *"What makes you think drinking would help you in this situation?"* The implicit judgment contained in the question is likely to cause the Veteran to feel criticized and, therefore, close off rather than open up the discussion.

In general, summaries serve four functions:

- 1) To begin or end a session with an overview that allows the Veteran to reflect on what has been discussed. This helps to lend coherence and continuity to treatment. It can be particularly effective as a form of agenda setting at the beginning of each session;
- 2) To transition to another stage of treatment (see the section on *key questions*);
- 3) To establish focus when the conversation has become unfocused; and
- 4) To organize a collection of statements of a particular type (e.g., consequences of drinking).

The acronym "**REDS**" identifies four additional MET techniques: Roll with Resistance, Express Empathy, Develop Discrepancy, and Support Self-efficacy. Each of these techniques is discussed briefly below.

REDS

Roll with resistance

Miller and Rollnick suggest that confronting clients who are unwilling to change often leads to an argument instead of a helpful, therapeutic interaction. Rather than confronting any resistance presented by a Veteran, MET suggests that you encourage the Veteran's personal power and individual responsibility using strategies of reflecting, shifting focus, and granting autonomy.

- **Reflect:** Therapists can respond to resistance with simple, empathic reflections. For example,

when initiating treatment with a Veteran who is unhappy about addressing substance abuse, you can respond with a statement such as, “*You are pretty upset at being forced into treatment.*”

- **Shift focus:** “*We don’t have to decide today whether you are an addict or not. We just need to try to work on some ways to make your life better.*”
- **Grant autonomy:** “*Only you can decide whether to keep drinking or not; I just want to help you make the best decision possible.*”

Express empathy

Empathy is a powerful predictor of positive outcomes in both mental health and substance abuse treatment. It is not uncommon to become frustrated when a Veteran you are working with denies, rationalizes, or minimizes a problem or his/her responsibility for it. However, in these situations, providers should attempt to appreciate the pain, frustration, and shame that often motivates these forms of resistance.

Develop discrepancy

According to the MI approach, internal motivation to change is achieved when a client recognizes the discrepancy between his/her current problematic behavior and his/her values. Thus, your task is to ask questions that help the Veteran clarify these values and recognize behaviors that violate these standards. These discussions will prompt the Veteran to make his or her own argument for changing current behavior. These discussions can also lead to the creation and development of change strategies.

Support self-efficacy

Due to the hardships they’ve faced, many Veterans on your caseload will have little sense of self-efficacy (i.e., little confidence in their own power to make changes in their lives). Thus, an important task for you as the Case Manager is to help clients identify sources of self-efficacy. For example, providers should ask Veterans about successful efforts they have previously made in their lives to change problematic behaviors. Maybe they once quit drinking for a

few months; maybe they maintained adherence to a medication plan for psychiatric symptoms or successfully resolved a problem with a family member or friend by calmly talking it out. You should ask questions that help Veterans identify these successes, indicating that they do have the ability to change things. You should also help Veterans on your caseload recognize the discrepancy between their values and their problematic behaviors. By helping them recognize their own power to change themselves for the better, you promote your clients’ internal motivation to change.

RELAPSE PREVENTION

The goal of Relapse Prevention [RP] is to teach the Veteran how to anticipate and cope with “triggers”—i.e., moods, thoughts or situations that increase the risk of using (Marlatt & Donovan, 2005). Relapse Prevention (Marlatt & Gordon, 1985) was developed from a combination of cognitive-behavioral and social learning models. The cognitive component assumes that, if people attribute a relapse to factors that are internal, global and/or uncontrollable, the risk for relapse is heightened. On the other hand, if your client views a lapse as external, unstable, and controllable, then the likelihood of a relapse is decreased.

The social component of RP works to reconcile the guilt, shame, and hopelessness that is often triggered by the juxtaposition between the Veteran’s previous ability to abstain from alcohol and/or drugs and the present lapse behavior. RP combines behavioral skills training with cognitive interventions designed to prevent or limit the occurrence of relapse. Psychoeducation is an important component of RP, as both the provider and the client must identify expectations.

Treatment using RP begins with the assessment of potential interpersonal, intrapersonal, environmental, and physiological risks for relapse (Marlatt, 1996). When incorporating the Stages of Changes methodology, RP emphasizes abstinence from substances when in the action or maintenance stages of recovery. RP interventions include teaching the Veteran how to use effective coping strategies and how to enhance self-efficacy

through the visualization of successful outcomes in high-risk situations. RP can be particularly useful in identifying early warning signs and high-risk situations among Veterans diagnosed with COD. For example, the exercise of identifying and role-playing high-risk situations with Veterans can enhance self-efficacy and skill development. As Veterans practice specific adaptive coping responses as part of treatment, they may gain confidence in their abilities to successfully handle similar high-risk situations in the future.

TWELVE-STEP FACILITATION (TSF)

As you work with Veterans in HUD-VASH who are also diagnosed with mental illness, substance abuse, or COD, you might want to consider becoming acquainted with the philosophy and practice of TSF, if you are not already. TSF is an evidence-based practice that, through groups such as Alcoholics Anonymous (AA) and other Twelve-Step recovery programs (Narcotics Anonymous, Gamblers Anonymous, and Nicotine Anonymous), has been an essential component in recovery from substance use and other addictions for over fifty years. Twelve-step groups are fellowships of men and women who meet to share perspectives on the negative consequences of addictions. These individuals help one another navigate the recovery process by providing a sponsor to serve as a companion and mentor on the journey to sobriety. Participation is

free of charge, and the only criterion for membership is a commitment to stop a specific addictive behavior. Different types of twelve-step groups (e.g., open meetings, step meetings, women-only meetings) are held in cities and towns across the United States. For more information about NA/AA and other 12-step groups, please visit: Alcoholics Anonymous <http://www.aa.org/> and Narcotics Anonymous <http://www.na.org/>. There is also a therapy manual available (Nowinski et al, 1995), and a training website (Sholomskas & Carroll 2006).

COGNITIVE-BEHAVIORAL THERAPY (CBT)

CBT is based on the assumption that negative feelings result from dysfunctional thoughts, beliefs, and assumptions about the self, the future, and the world. Veterans may exhibit these negative feelings in the form of explicit, verbal self-statements, or with “silent assumptions.” Silent assumptions may vary depending on the different symptomatology of each Veteran; however, when reinforced, these beliefs manifest in ways that are extreme extensions of the mental health disorder.

For example, Veterans suffering from depression tend to believe they deserve to fail or be rejected, and often believe that putting any effort towards something positive will result in disappointment and humiliation. They are increasingly likely to be pessimistic and self-critical, expecting failure and—when things don’t work out exactly as hoped—give

DYSFUNCTIONAL COGNITIVE SCHEMAS	
ARBITRARY INFERENCE	Drawing inappropriate conclusions based on faulty, insufficient, or contradictory information
CATASTROPHIZING	Minor disappointments are turned into major catastrophes
ALL-OR-NONE THINKING	The world is viewed in absolute, mutually exclusive terms
PERSONALIZATION	Relating external events to oneself without the presence of any evidence to justify the belief
DISQUALIFYING THE POSITIVE	Positive experiences are rejected because they are trivial or undeserved
EMOTIONAL REASONING	“All negative emotions reflect the true state of the world”

up or blame themselves. The result is resignation, learned helplessness, chronically low task persistence, and frustration intolerance.

This perpetual reinforcement of negative beliefs surfaces differently when the client is diagnosed with a personality disorder, and variance is based on the nature and extent of the disorder. Manifestations may include attachment issues—over- or under-valuing emotional connections with others—distorted views about entitlement or responsibility, or extreme issues with trust.

CBT interventions are designed to help clients identify and alter problematic thoughts and assumptions when they arise, as well as to guide an examination of underlying “cognitive schemas”.

According to Beck, schemas can be thought of as cognitive templates through which information is processed and interpreted.

To address and further understand the root causes of such negative thoughts and assumptions, you can ask Veterans with whom you are working to explain the circumstances of how the event or belief in question could actually take place. Depending on psychiatric symptoms and the severity of these symptoms, responses to these questions will vary. However, the next step is to work with the Veteran to examine the evidence available to support or refute the belief in question, and to ask whether or not there is any chance of exercising positive influence on the outcome. The treatment team can also encourage use of a thought diary. In the thought diary, the Veteran can record beliefs about specific scenarios and the negative thoughts and emotions that follow. This exercise provides both you and the Veteran with an opportunity to review thought processes and patterns, discuss the likelihood of occurrence, and develop strategies for managing such thoughts when they arise.

SOCIAL SKILLS TRAINING [SST]

Social Skills Training [SST] was initially developed in the 1970’s for individuals who needed help with community integration, relationship development, and comfort in social situations (Bellack, 2004; Mueser & Bellack, 2007). Based on social learning principles, SST is not discussion-based—rather,

it focuses on rehearsing behavior. SST involves teaching clients essential interpersonal skills by breaking complex behaviors down into simpler, easier-to-understand components (Bellack, 2004; Mueser & Bellack, 2007). The Case Manager, or other member of the treatment team, can teach the Veteran how to perform these simpler steps through role-plays and, once the Veteran has mastered these simpler tasks, combine them so that the Veteran can perform the desired, more complex behavior. Throughout this process, providers will give feedback, reinforce success, and repeat until the Veteran feels more confident and more comfortable (Bellack, 2004). SST can play an important role in the day-to-day functioning of formerly homeless Veterans suffering from mental illness, substance abuse, and COD, especially as they transition from residential care to community living.

Treating Co-Occurring Psychiatric and Substance Use Disorders

As many individuals suffering from mental illness also abuse controlled or illicit substances, a number of integrated psychosocial treatment models using evidence-based approaches have been developed to address co-occurring mental health and substance use disorders (Ziedonis et al, 2005). Many models, especially those that were developed as part of a research study, are indicated for specific pairings of mental health and substance use disorders – for example, co-occurring depression and cocaine addiction (Nunes et al, 2005). However, other approaches have a broader focus, and are applicable across a variety of mental health and substance abuse combinations. Since these broader approaches assume that individuals within certain diagnostic clusters can be treated with the same intervention, or set of approaches, we believe that they more closely address the “real world” needs of Veterans in HUD-VASH. As your team chooses treatment models for use with your clients, and for additional continuing education or training opportunities, it may be helpful to remember that many of these approaches have been manualized for easy implementation and to promote model fidelity. Many co-occurring disorders treatment models are more similar than different, and often

include a combination of the treatment approaches highlighted in the previous section. A brief list of some of the currently-available co-occurring disorders treatment manuals is below.

AVAILABLE PSYCHOSOCIAL CO-OCCURRING DISORDERS TREATMENT MANUALS

Seeking Safety (Natjavits, 1992)
Cognitive-Behavioral Therapy (Cuffel, 1994)
Dual Recovery Therapy (Ziedonis, 1997)
Motivational Enhancement Therapy (Carey, 2006)
Behavioral Substance Abuse Treatment for Serious Mental Illness (Bellack et al., 2006)
Maintaining Independence and Sobriety Through Systems Integration Outreach and Networking [MISSION] (Smelson et al., 2007)
MISSION-VET (Smelson et al., 2011)

Using an integrated treatment approach—in which both the mental health issue and substance use disorder are treated simultaneously and by the same clinician or treatment provider—is preferable (Ziedonis, 2004; Essock et al., 2006; McHugo et al., 2006; Drake et al., 2008). The creation of a single treatment plan, executed together by the Veteran and a single provider, echoes the concerted approach of simultaneously addressing co-occurring mental health and substance use disorders.

A significantly less desirable alternative is a concurrent but non-integrated treatment approach, in which mental health or substance abuse problems are treated simultaneously, but by different providers (Mueser, et al, 2003, pp. 17). This latter approach is often marked by disorganized communication, ineffective care coordination, and multiple competing treatment plans.

Consistent with existing therapeutic models that manage both substance abuse and psychiatric conditions simultaneously, several researchers (Bellack et al, 2002; Drake et al, 1998; Shaner et al, 1997; Ziedonis, 1997; and Minkoff et al, 1989) have developed integrated models that incorporate the use of MI and MET with clients suffering from co-occurring disorders to better facilitate treatment

engagement. Others have integrated motivational enhancement approaches with cognitive behavioral therapies, while others have integrated MET with case management approaches, such as CTI, to meet the unique needs of individuals diagnosed with COD (Smelson et al., 2007; Smelson et al., 2011). These models promote the facilitation of treatment engagement by providing the client with service linkages to useful community resources.

Blending Assertive Community Approaches with Mental Health and/or Substance Abuse Treatment

It can be especially difficult to engage people with mental health and substance use disorders in recovery. This is further complicated by mental health care systems that are not equipped to provide integrated care for those suffering from COD. The gap in treatment resources is being addressed, however, by researchers who have demonstrated the success of blended approaches. For example, Bellack blended Social Skills Training [SST], Motivational Interviewing [MI] and Relapse Prevention [RP] to treat substance abuse in people with severe and persistent mental illness (Bellack, 2001). In a randomized clinical trial (RCT), Bellack's structured, integrated behavioral treatment model (BTSAS) was found to be significantly more effective than a non-structured control treatment in keeping patients engaged in treatment and abstinent from illicit substances. Similarly, Ziedonis and colleagues found that their Dual Recovery Therapy [DRT] approach for cocaine addiction, which also combined RP, SST and MET into an integrated model of treatment, was more effective than a control treatment in engaging patients in both individual and group treatment, retaining patients in treatment, reducing the number of psychiatric re-hospitalizations, and demonstrating reduced cocaine use among those who received DRT when compared to those who received services in the control condition (Ziedonis & Fisher, 1994; Ziedonis et al, 1997; Ziedonis & Trudeau, 1997; Ziedonis et al, 1998; Ziedonis & Stern, 2000).

Along these lines, several investigators have developed and examined the effectiveness of integrated treatment approaches that focus

especially on the challenges of treatment engagement. However, it was found that highly individualized services, when provided directly to consumers in their own homes or communities, improved outcomes for patients transitioning to community living. As the successes of mobile outreach teams and service delivery *in situ* become apparent, components of Assertive Community Treatment, or ACT (Stein & Test, 1980), were integrated into blended approaches for co-occurring disorders treatment. Systematic combination of ACT's locally-based services with other treatment techniques has enabled Case Managers to meet the needs of clients whose recovery goals have not been adequately addressed by more traditional treatment approaches (Bellack et al, 2010; Drake et al, 2001; Smelson et al, 2007).

Unsurprisingly, the use of ACT-based models, such as Critical Time Intervention (CTI), have been found to be successful in assisting individuals during the critical transition from institutional care to outpatient treatment, and also in preventing recurrent homelessness among persons with SMI (Susser, et al, 1997). CTI is different from traditional case management within the VA in that it is time-limited (often nine months, although others have shortened the schedule of services), and was specifically designed to help homeless clients suffering from mental illness who are transitioning from institutional care to community living. It also provides these individuals with the "critical" support required to prevent recurrent homelessness. See the table below for a comparison of CTI and traditional case management.

CTI	Traditional Case Management
Focus on intervention at a "critical time" (for example, the transition from the institution to the community)	No specific focus on critical transitions
Time-limited	Open-ended
Focus on prevention of recurrent homelessness and continuity of care	Focus on comprehensive array of service needs

Dixon and colleagues (2009) found a three-month version of CTI to be helpful in promoting continuity of care for individuals with SMI post discharge from psychiatric hospitalization. When using CTI in combination with other treatment approaches, it is essential to initiate CTI while the client is still receiving inpatient services in order to demonstrate utility and establish a rapport with the client while s/he is in a stable environment.

Investigators have also found the combination of CTI and co-occurring disorders treatment to be successful in reducing alcohol use to intoxication, increasing both inpatient and outpatient treatment attendance, engaging clients in substance abuse and mental health treatment services, and preventing psychiatric re-hospitalizations (Smelson et al, 2007; Smelson et al, 2010). Based on these findings, Smelson and colleagues developed the Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking for Veterans (MISSION-VET) approach, released in early 2011, and available on the VA's National Center on Homelessness Among Veterans website <http://www.va.gov/HOMELESS/NationalCenter.asp>. The MISSION-VET approach was designed specifically for formerly homeless Veterans with COD who are transitioning from VA or VA-supported residential care to a new housing placement in the community, such as those housing placements provided through the HUD-VASH program.

Both the individual treatment components and the integrated treatment models described in this chapter will serve as valuable resources for treating Veterans with mental illness, substance abuse, and COD. While we did not review all of the evidence-based practices, we did highlight some of the evidence-based practices we felt might be most useful for Veterans in the HUD-VASH program. For more information and review of additional evidence-based practices, please visit SAMHSA's National Registry of Evidence-based Programs and practices <http://nrepp.samhsa.gov/>. While the use of these evidence-based practices will not address every issue faced by the Veterans on your caseload, we encourage you to consider the use of multiple approaches simultaneously, such as those combinations used in BTSAS, DRT and MISSION-VET models, as these integrated treatment models

increase the likelihood that more of the Veteran's service and care coordination needs will be met.

Additionally, it is essential for the services provided by the HUD-VASH Case Manager to be compatible with the goals of the Veteran receiving care. For example, while outcomes such as abstinence or reduced drug use, fewer reported psychological symptoms, and fewer inpatient hospitalizations are ideal, newer treatment paradigms also encourage Case Managers and other providers to pay more attention to the attainment of non-traditional outcomes such as independence, employment, and higher levels of satisfaction with the relationships in their lives (Drake et al, 2001).

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Test Your Knowledge!

Quick Check: Answer "true or false" to the following statements to check your knowledge about evidence-based practices for people with co-occurring disorders.

- 1) The most commonly observed mental health problems among homeless Veterans include mood disorders, PTSD, and schizophrenia.
- 2) Among homeless Veterans, the most commonly observed substance of abuse is methamphetamine.
- 3) Chronically homeless Veterans are surprisingly well connected to outpatient and preventive treatment services.
- 4) Motivational Enhancement Therapy (MET) is built on the idea that each client approaches treatment at different levels of readiness to change behavior and/or address the symptoms associated with their mental illness.
- 5) "Am I understanding correctly?" is a question that demonstrates MET's open-ended questions technique.

- 6) Rolling with resistance is a MET technique exemplified by this statement, "We don't have to decide today whether you are an addict; we just need to try to work on some ways to make your life better."
- 7) The goal of Relapse Prevention is to teach the Veteran how to anticipate and cope with "triggers" (i.e., moods, thoughts or situations that increase the risk of using).
- 8) Twelve-step groups cost only five dollars per session to attend.
- 9) Veterans who are depressed are more likely to be pessimistic and self-critical.
- 10) Role playing is a technique used in Social Skills Training.
- 11) The advantage of a broad-based diagnostic treatment intervention is that it more closely addresses the "real world" needs of Veterans in HUD-VASH.
- 12) New treatment paradigms encourage Case Managers and other providers to pay more attention to the attainment of non-traditional outcomes such as independence, employment, and higher levels of satisfaction with the relationships in their lives.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) Motivational Enhancement Therapy's fundamental skills are open-ended questions, affirmation, reflective listening, and summarizing. Can you name an example of each of these techniques?
- 2) It is not uncommon for you as the provider to become frustrated when a Veteran with whom you are working rationalizes or minimizes a problem or his/her responsibility for it. What are some techniques you can use to actively engage Veterans in addressing this kind of behavior without ostracizing them from treatment?
- 3) What are some examples of dysfunctional cognitive schemas and what are some ways that providers can respond to these types of thoughts and assumptions?
- 4) What psychosocial co-occurring disorders treatment manuals are available for further reference in understanding and addressing co-occurring disorders?

Case Management Integration with Psychiatry and Other Mental Health Services

What's in This Chapter?

Case Managers and Peer Support Specialists can provide psychiatrists and other mental health providers with invaluable insights into the daily living of the Veterans they serve.

In this chapter you will learn

- How to facilitate psychiatric and other mental health services;
- How to support adherence to mental health treatment plans; and
- Tools for avoiding and managing crises.

After reading this chapter, you will know how to take a proactive approach to supporting the work of treatment providers working with HUD-VASH Veterans on your caseload.

Importance of the Case Manager

A significant percentage of the Veterans in the HUD-VASH program will be involved in mental health treatment of one form or another. An effective and well-integrated Case Manager can have a profound impact on the Veteran's successful recovery from acute mental health disorders.

Within an interdisciplinary team, it is common for the each member to have a different type of relationship with the client, and each type of relationship will have a different basis for communication. If, for instance, the pain of a service-connected injury is

played down to a primary care provider, the Peer Support Specialist might know that this is because this Veteran, who is in active recovery from a narcotics addiction, wants to avoid being prescribed a drug with a street value. Similarly, a psychiatrist who is working with the Veteran on cognitive behavioral therapy for severe depression will have a different understanding of the Veteran's thought processes than, for example, even a 12-step sponsor. Although the Veteran is the common concern, each member of a treatment team receives different types of information, at varying levels of depth, in a different way.

At the center of all of these relationships is the Veteran's Case Manager, who will often be viewed by the Veteran as a confidant, an ally, and an advocate. Equally important is the Case Manager's role as an honest broker—serving as a liaison among different members of the treatment team and providing clear, accurate information. By appropriately participating in, and augmenting the relationship between, the Veteran and the psychiatrist (or other mental health provider), the Case Manager can potentially improve the diagnostic database, allow for earlier recognition of emerging problems, modify intervention strategies, and improve adherence to the prescribed treatment regimen. The Case Manager can extend the view and awareness of the treating mental health professional, and can help convey important information on behalf of the Veteran.

By working as a team, the variety of perspectives and observations can be incorporated into a broader and more complete picture of the Veteran's world than any one clinician alone could formulate.

CASE MANAGER COMMUNICATION CAN ENHANCE THE PROVIDER-VETERAN RELATIONSHIP

TREATMENT OBJECTIVE	CASE MANAGER'S ROLE	OUTCOME
Support the Veteran's treatment and recovery needs	Communicate important information on behalf of the Veteran when needed	Improve diagnostic database for clinicians by communicating concerns, observations, information
		Allow for earlier recognition of emerging problems by keeping treatment team informed about Veteran's lifestyle, work, education, housing—including goals, achievements, setbacks
Reinforce and inform the Provider's treatment plan	Convey own observations, concerns, information	Extend view and awareness of treating mental health professional
		Improve Veteran's adherence to prescribed treatment strategies
		Help modify intervention strategies

"The Case Manager's observations and relationship to the Veteran can provide ongoing assistance in achieving the therapeutic goals of the mental health treatment plan..."

Obtaining History

The ability to accurately diagnose an illness or understand a situation is directly related to the amount and quality of information obtained through history and examination.

Obtaining a good history is essential but not always simple, especially if the only source of information is the patient. Human beings strive for some form of order or understanding. Events are put on timelines, connections are made—and, in some cases, causality is inferred in order to “make sense” out of what is happening. This is one strategy by which an internal sense of mastery, or control, can be achieved. In order to help communicate information to others, it is internally edited and formatted. The connections that are made, the theories that are generated, and the organization that is developed serve clear functions; however, this framework also limits the degree to which a person can provide a truly objective, unaltered, factual history. The Veteran patient will edit and select information based on what he/she perceives as important and relevant and, depending on the skill of the clinician and the Veteran's perception, may also provide history with intent to please or satisfy the interviewer. This can be especially true when the issues are highly personal for the Veteran, or when he or she feels that there is a lot at stake—

In mental health care, history is vital:

- Many symptoms are chronic, but still wax and wane over time

- Course of symptoms defines and distinguishes one mental health syndrome from another, yet the course is not always evident or expressible

- Symptoms often do not lend themselves to direct examination, verification, etc.

in these cases, treatment team members, or even the same clinician on different visits, may receive different amounts of spontaneous information about the Veteran’s subjective experiences and opinions. Assumptions on the part of the Veteran concerning the relative role, interest and expertise of the listener also factor into this variance. Time-limited appointments with psychiatrists and nurse practitioners may convey that only certain factual material is to be discussed; this may also positively reinforce certain disclosures and responses, while having the opposite effect on others. This is not to be

confused with withholding, malingering, or falsifying information—rather, it is a limitation shared, to some degree, by all historians.

When the challenge of providing unaltered, uninterpreted, factual information is coupled with the inherent subjectivity of many questions and symptoms in mental health, it is easy to see why an account of an illness or problem may sound quite different at different times and to different listeners, and might vary still more from what an outside observer would witness.

CASE MANAGERS CAN HELP DIFFUSE SOME OF THE LIMITATIONS OF FORMAL MENTAL HEALTH HISTORY		
DOMAIN	DESCRIPTION	CASE MANAGER TASKS
ESTABLISHING AN UNDERSTANDING OF THE VETERAN’S “NORMAL”	Changes in sleep, appetite, energy, social engagement, interest in hobbies, cleanliness, and tolerance of stimuli are but a few items of significance within a typical psychiatric history. While there is some normal variation in all of these areas, they are also prone to disruption and potentially amenable to intervention if they are pieced together and evaluated appropriately.	<ul style="list-style-type: none"> ▪ Note baseline levels ▪ Note changes ▪ In addition to what is reported at intake, the Case Manager can make comments, observations ▪ Ask follow-up questions as appropriate; work to elicit additional information that could be vital to the mental health provider
ACTIVITIES OF DAILY LIVING	Seeing the Veteran in his or her home or in a community setting can provide information that isn’t available in an office visit	<ul style="list-style-type: none"> ▪ Look for consistency between what is reported and what is observed ▪ Pay close attention even during casual conversations, as this is when important details might emerge
SYMPTOM FOCUS	During a diagnostic interview or medication appointment, problems and symptoms are typically the focus	<ul style="list-style-type: none"> ▪ Engage the Veteran on hopes, fears, dreams, goals ▪ Reinforce the value of these, and use them to help the mental health provider give context to the treatment plan
TROUBLESHOOTING	Forgetfulness, embarrassment, concerns about consequences can lead to less-than-accurate reporting clinical appointments. Dangerous medication interactions are a concern, as are undisclosed or inaccurately explained lifestyle habits that lower the efficacy of certain medications (i.e., relationship between nicotine and antipsychotics)	<ul style="list-style-type: none"> ▪ Explore over-the-counter medication use, use of herbal or vitamin supplements, etc., with the Veteran ▪ Compare observations with documented history, medication record, etc. ▪ Convey discrepancies

As outlined above, seeing the Veteran in his or her home, or in a community setting, can provide information that isn’t available in an office visit. Is the home grossly unkempt, suggesting apathy, or is it

overly fastidious, suggesting compulsive cleaning? Are beer cans or wine bottles lying around, and is this consistent with reported use? Are windows or the T.V. covered, suggesting paranoid fears? Not

everything is obvious, even when viewed directly, but by noting the condition of the home, of the Veteran, and how he or she seems to be interacting with the environment, the Case Manager can be the eyes of the treating mental health professional and augment the reported history with additional facts and details.

In addition to direct observation, the nature of the Case Manager's interactions with the Veteran can be a vehicle for obtaining information that may be not disclosed to a mental health provider. High anxiety, worsening depression, emerging psychosis, or developing mania can impair insight and judgment, making it difficult for Veterans suffering from these issues to observe themselves and convey their experiences. For example, a person may describe sleep habits very differently when responding to a closed question in a structured interview during a scheduled appointment than when asked about the same issues in a more conversational way.

It is common for a Veteran patient to attempt to conform to the provider's style and needs during a diagnostic interview or medication appointment. Problems and symptoms are typically the focus. In a meeting with a Case Manager, however, the tone is typically more conversational and less formal. It is more likely for hopes, fears, and wishes to be part of the discussion. It cannot be immediately assumed that one interaction is inherently superior to the other, but if disparate or unique reporting is identified, additional efforts to gain clarity and accuracy can be pursued. Obtaining information that may vary from that reported to the psychiatrist is not only of potential value to the psychiatrist, but is also of value to the Veteran, as it allows for the most accurate clinical picture and appropriate treatment. The take-home point is not to assume consistency in all reporting and to consult the medical record frequently and maintain open communication with others on the treatment team.

An accurate history is not just important in the early stages of care, but remains vital to the monitoring of stability and treatment effectiveness. The Case Manager's observations and relationship to the Veteran can provide ongoing assistance to the therapeutic goals of the mental health treatment plan. Indeed, in some cases, specific assessment tools can also be utilized between scheduled

appointments to improve the disease monitoring process. A number of surveys and questionnaires exist for various psychiatric illnesses which can provide a measure of symptom severity that the primary treatment team may find useful in guiding treatment. One example is an instrument used in depression care management, the Beck Depression Inventory (BDI). It is a Veteran-completed questionnaire that can assist in symptom and response tracking vis-à-vis the treatment course. While the principal treating provider should be consulted and local policies should be considered prior to administering any specific instrument, when indicated, the Case Manager can help ensure that measures are completed and the results relayed in a timely manner. Field interventions, such as the completion of a questionnaire, can make appointments with prescribing providers more efficient, and, in some cases, can potentially allow for timely interim medication adjustments.

Facilitating Treatment

With adequate information, a mental health professional should be able to generate a diagnosis and prescribe a treatment. At subsequent visits, the success of the treatment is evaluated and, if needed, an adjustment is made to the regimen. Occasionally, a lack of response or a unique response to treatment may trigger reconsideration of a diagnosis. The ability to follow the prescribed treatment plan is, therefore, important for two reasons: it may be of value to the Veteran in light of his or her recovery goals, and it may re-inform the clinician's opinion of the condition itself.

A provider may prescribe medications but also commonly make recommendations and suggestions for lifestyle changes. These may involve exercise, education, hobbies, or volunteer projects, or may center around nutrition plans or a nighttime routine for sleep (sleep hygiene). Apart from issues of more clear resistance to the treatment, which will be covered later, there can be some very real challenges with translating these lifestyle recommendations into actions. The Case Manager should review the provider's recommendations in common language, and should revisit the "new habits" often.

In addition to potential implementation challenges, there may also be barriers in understanding what the treatment recommendations actually are. Memory difficulties, problems with attention, and language barriers are all common in patients receiving mental health care. Some patients may also have very concrete thought process and be unable to generalize or comprehend figures of speech. While most providers try to use appropriate language to ensure that their recommendations are understood by the patient, it is still quite possible for parts of the explanation to be forgotten, and certain points “lost in translation.” Repeatedly reviewing all recommendations in a non-hurried, concrete manner, using different explanations and examples, if necessary, can be a tremendous help to everyone.

As the Veteran, clinician, and Case Manager reach an agreed-upon understanding of the treatment plan, the recommendations should be reviewed in light of the Veteran’s actual environment.

A recommendation to get exercise may be compromised by the lack of a nearby gym as well as by preconceptions about what constitutes exercise. This may not be expressed to the recommending provider at the time of the appointment, and it may fall to the Case Manager to isolate the issue, discuss it, and find a solution. If no alternative can be identified, the Case Manager and the clinician can discuss a timely plan modification.

Along the same lines, providing information about the Veteran’s actual environment and lifestyle can be very helpful to the mental health provider, and can allow the clinician to make treatment recommendations that fall within the scope of the Veteran’s abilities and environmental limitations. Cooking skills, or lack thereof; disposable income; access to transportation; proximity to community resources; and other realities of the Veteran’s habits and behavior are all potentially important. When the Veteran does not or cannot communicate important lifestyle information, the Case Manager can fill in the blanks for the mental health provider.

Frank conversations about what parts of the treatment plan the Veteran is actually implementing, in a manner that does not convey displeasure or disappointment, can provide insight into what elements of the treatment plan are working, and which can be improved. Relating lifestyle changes

to potential medication issues is often a critical step in engaging the Veteran. Explaining that it is impossible to determine which symptom is a side effect of medication, and which is a side effect of poor nutrition or poor sleep hygiene, for example, is an important step in facilitating the Veteran’s investment in his or her own treatment.

It may also be helpful to explain that most providers begin with the lowest-risk medications and treatments, but often these require more lifestyle changes on the part of the Veteran. If treatment fails due to implementation barriers—for instance, a Veteran’s inability to follow a schedule that helps determine whether or not a medication is disrupting sleep—a second-line medication or treatment strategy, with more potential side effects, may be the result. Furthermore, each step toward treatment compliance is an opportunity for esteem-elevating self sufficiency.

Case Managers should be proactive in seeking their own understanding so they can be assets to clients and to treatment teams. When Case Managers ask for clarification of words, meanings of certain terms, etc., during joint meetings with the Veteran and the provider, it serves all parties—eliminating both the barrier to implementation and the hesitation of inquiry.

Supporting Adherence

A high percentage of both mental health and general medical patients have poor adherence to a medication regimen as ordered by a treating provider. Poor understanding of risks and benefits from treatment, fear of side effects, actual experience of side effects, forgetfulness, confusion, nonchalance, and, in some cases, a potential secondary gain from medication diversion, are some potential causes for non-adherence. Being aware, being inquisitive, and being responsive can help improve medication adherence and treatment success.

The informed consent process, the risk descriptions in pharmaceutical packaging, advertising, and information from the internet can all make the potential risks of treatment seem overwhelming and out of proportion to the potential benefits.

If concerns about potential side effects are an identified issue for a Veteran, it can be very helpful to clarify the concerns, actual risk, and what the response would be. Are the feared side-effects common or very rare? Are they reversible? Are they time-limited? What is the plan if the feared side effects actually emerge? Exploring these items with the Veteran can, at times, alleviate concerns. Any further issues that emerge, or perhaps a concession to a more informed risk-benefit analysis, that emerges, can be used in follow-up with the prescribing provider so that, if necessary, an alternative agent can be utilized.

Many of the same points are relevant when side effects do emerge, and even more so when they limit adherence. Psychiatric medications, especially those that fall into certain pharmacological categories, can negatively impact sleep, energy, appetite, weight, bowel functioning, physical movement, muscle control, and sexual functioning. While this is an

incomplete list, it does demonstrate why a Veteran might consider ad hoc treatment discontinuation. It is good practice for Case Managers to become familiar with the most common and, potentially, the most severe, side effects of their clients' medications.

Analysis of medication side effects can be tricky, as many side effects are very similar to the symptoms of the illnesses they are designed to treat. Other effects can be influenced by, for instance, whether or not the medication is taken on a full or empty stomach, or if it is taken in combination with other agents (including other prescribed, over-the-counter, and/or herbal preparations). The key point is to be aware that medication discontinuation is a common phenomenon, and the sooner it is recognized, and the rationale behind what it identified, the better. Some Veterans may be reluctant to spontaneously bring up problems such as sexual dysfunction, so tact is necessary in eliciting information that the prescribing provider can use to modify treatment.

CASE MANAGERS CAN HELP SUPPORT MEDICATION ADHERENCE	
PATIENT/CLIENT CONCERN	OPPORTUNITY FOR SUPPORT
Concerns about potential side effects	<ul style="list-style-type: none"> ▪ Work to help clarify actual risk and potential response ▪ Are feared side-effects common or very rare? <ul style="list-style-type: none"> ○ Are they reversible or time-limited? ○ What is medical plan if side effects to emerge?
Actual experience of side effects	<ul style="list-style-type: none"> ▪ Become familiar with most common and potentially most severe side effects of common psychiatric medications, and of your clients' medications ▪ Introduce reminders for or investigate mitigating factors: full stomach, empty stomach, with food, etc. ▪ Be aware that some Veterans may not bring up problems like sexual dysfunction, etc.; be discreet and tactful ▪ Prescribing provider may be able to adjust dose, modify schedule, add an antidote med, etc.
Abrupt medication stoppage	<ul style="list-style-type: none"> ▪ Check in regularly with Veteran and ask about medication adherence, problems, concerns, etc.
Memory problems, confusion, scheduling problems	<ul style="list-style-type: none"> ▪ Help provide pill boxes and assist with filling if necessary; observe if there are meds whose supplies change abnormally quickly or slowly ▪ Consider bubble-packed medications if there is a higher need for supervision

By becoming aware of a medication issue, the prescribing provider may be able to adjust the dose, modify the schedule, add an antidote medication, suggest behavioral strategies, or provide education that can allow the Veteran to continue with treatment. In other cases, the treatment may need to be changed more dramatically, but having information in a timely manner is key to relapse prevention or symptom exacerbation caused by medication non-adherence.

In most cases, a short time off treatment will not trigger an exacerbation, but if the Veteran stops his or her meds soon after having them prescribed—and it is not known for several weeks—serious problems could arise. Similarly, the abrupt cessation of certain meds, including some antidepressants and anti-anxiety medications, can trigger withdrawal symptoms that can, at times, be quite uncomfortable and severe. High rebound anxiety, insomnia, and seizures are some potential complications of abrupt medication withdrawal.

In the case of memory problems or confusion, additional tools may aid the Veteran in adhering to the treatment regimen. Pill boxes can be helpful, but many patients will either struggle with filling the box correctly or may actively defeat the pill box by accessing meds early—or in excess—in order to achieve a desired effect. The latter is more likely to occur with substances of abuse such as tranquilizers and pain medications. Observing the Veteran's supply of medication, and comparing it with prescription instructions, could signal the need for a higher degree of medication supervision. In this case, there are options such as prefilled pill boxes, bubble-packed medications, or other, more secure, medications of medication delivery.

Crisis Avoidance/Management

The treatment prognosis is best when the diagnosis/diagnoses is/are accurate, the treatment plan is comprehensive and well-developed, the Veteran is adherent and conscientious, and the Case Manager and treatment team are involved and aware. However, even in an ideal situation, decompensation may still occur due to medical conditions or status changes, changes in environmental stressors, or natural progression of an illness.

While symptom control is important as far as mitigating the patient's pain, suffering, or mental anguish, and also because of the variety of possible negative social consequences, there is evidence that, in a variety of conditions, the long-term course and prognosis worsens with each recurrence. Extended periods of psychosis may reduce baseline functioning; each manic and depressive episode can increase the risk for subsequent episodes. It is also widely known that suicide risk is elevated in a variety of psychiatric conditions.

Remission and recovery are always the goals, and may be realistic outcomes in many cases. However, recovery may not equate to a complete absence of symptoms. In spite of aggressive management of symptoms and conditions, treatment results may be incomplete. If the patient has adapted to symptoms over time, and has appropriate supports, he or she may still be able to function very effectively, despite symptoms. Lingering paranoia or hallucinations, suboptimal mood stability, or residual anxiety may be realities of daily life for some Veterans.

Recognizing this reality, and working to understand the specifics of the client's condition, are important for optimal functioning and for effective case management. The Case Manager should prioritize communication with the treating clinician and should maintain familiarity with the Veteran's baseline status. The severity of baseline symptoms can impact individual goals and outcomes, but stable symptoms typically do not cause the same level of distress and risk as acutely worsening symptoms—even if the severity appears less pronounced in the latter.

Thus, it is clear that effective monitoring for worsening symptoms is dependent upon a good understanding of the Veteran's functioning at baseline and an awareness of several key indicating factors.

While relatively non-specific, sleep is often one of the earliest signs of a declining management of mental illness. Depending on the condition(s) being treated, the threshold for intervention may vary; establishing expectations or guidelines from the clinician can be helpful in addressing sleep difficulties. For certain patients with bipolar illness, even short periods of sleeplessness may quickly lead to severe mania and

may warrant a rapid appointment or intervention. Gaining a sense from the Veteran and the provider about the sleep patterns and expectations can be very helpful.

In addition to sleep, changes in appetite, energy, grooming and participation in activities may also be signs of a change in status. A Veteran may report symptoms (loss of appetite, poor sleep, etc.), but there may also be observed signs (e.g. unkempt appearance, talking louder or faster) of which the Veteran is not aware. As a Veteran gets more depressed, he or she may cease certain activities, become more delayed in responses, or become more irritable. In a developing manic episode, a Veteran may become more talkative and energetic. He or she may present as enthusiastic, playful or irritable. More sexual or religious references may be present in speech or behavior, and risky or frivolous behavior may begin to manifest itself. Psychosis can begin as withdrawal, disorganization, or poor attention as the Veteran responds to paranoid concerns, has difficulty processing information, or is distracted by hallucinations.

A negative change is always a stress that can trigger further worsening. For example, a reduction in income or a new medical problem can lead to worry, sleeplessness, and mood instability, which may precipitate substance misuse or other problems, which can quickly multiply. Although the cause and effect relationships can often be unclear, when social stressors mount, there is a definite possibility that psychiatric stability is, at a minimum, at risk to deteriorate.

The preceding signs are an incomplete list, but they speak to the value the Case Manager can bring to the treatment process by making observations in the field that might otherwise go unnoticed. In all cases, suicidal thinking can develop and any statements of hopelessness or references to dying should not be ignored and need follow-up. With some Veterans, it may be useful to have candid discussions concerning their past patterns and what tend to be their earliest signs and symptoms. A person may struggle to recognize emerging difficulties during an acute exacerbation of their illness, but may still be able to comment on past experiences and collaborate on an action plan at a time of relative stability.

Not every observed behavior is a warning sign, but vigilance, observance, and communication with the clinical team can facilitate interventions that may halt emerging problems.

CASE MANAGERS CAN HELP MONITOR PSYCHIATRIC STATUS	
SYMPTOMS	SIGNS
Changes in sleep patterns	Social withdrawal
Changes in energy level	Unkempt appearance
Appetite differences	Changes in speech and vocal patterns
Expressed changes in mental status/ mood	Delayed responses
<i>Be aware; note changes; exchange information to treatment provider. Pay particular attention to social stressors and negative developments in the Veteran's life. Become as familiar as possible with the Veteran's baseline mental health status, including characteristics and patterns in activities of daily living when symptoms are well-managed.</i>	Marked increase in energy, talking
	Irritability
	Increase in sexual or religious references in speech and behavior
	Increased risk-taking or frivolous behavior
	Withdrawal, disorganization, poor attention span, distraction

There will be times when a Case Manager is confronted with an acute and unexpected crisis in the field. A clear understanding of the specific local protocols, emergency services and response system is vital in such cases as resources and statutes vary greatly across communities.

The potential benefits a Case Manager can bring to the mental health care of a Veteran are, in many ways, predicated upon good communication between the Case Manager, the Veteran, and other mental health providers. There will be some variation in the particulars concerning the

relationship between the mental health provider and the Case Manager, depending on local structure; yet, regardless of the model, the Case Manager and the clinician should be in close contact. If the Case Manager can attend appointments with the Veteran, this is a valuable tool. Joint meetings can reinforce the concept of team-based care, deepen care coordination, and help eliminate miscommunication. In addition to bringing another source of information to the appointment, the Case Manager can also observe the relationship the Veteran has with the mental health provider and witness the Veteran's ability to express him or her self in that setting. If the Veteran is unable, for whatever reason, to articulate issues or concerns, the Case Manager can assist in the moment, but can also work with the Veteran between visits to improve communication and self-sufficiency skills.

Along these lines, it can be helpful for the Case Manager to initiate an open discussion with the client and the clinician around how to best be of assistance during, and in between, appointments. As with all efforts, the goal is for a Veteran-centric approach that matches the intensity of the intervention with the needs of the Veteran, while concurrently moving the Veteran toward increasing levels of independence.

Test Your Knowledge!

Quick Check: Answer "true or false" to the following statements to check your knowledge about integrating your work with psychiatry and other mental health services.

- 1) Veterans are likely to share the same information with each team member and treatment provider they encounter.
- 2) A provider may prescribe medications but may also commonly make recommendations and suggestions for life change.
- 3) Case Managers can assist with treatment adherence by translating the recommendations of providers into actions for Veterans.
- 4) Cooking skills, disposable income, access to transportation, and the proximity to community resources are all important pieces of information for a Case Manager to be aware of but are irrelevant to the provision of treatment.
- 5) It is good for Case Managers to become familiar with the most common and potentially most severe side effects of the medications their clients are taking.
- 6) Once a Veteran has been taking medication consistently for 6 weeks, s/he is likely to continue indefinitely.
- 7) While remission and recovery are the goals for some patients, even in the best possible scenarios, recovery may not equate to a complete absence of symptoms.
- 8) Withdrawal, disorganization, or responses to paranoid concerns can be signs of developing psychosis.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) What are some items of significance within a typical psychiatric history?
- 2) The Case Manager should be proactive in seeking his or her own clarity about treatment recommendations so they can be an asset to their clients. What are some ways Case Managers can be sure they fully understand the treatment prescribed for individual Veterans?
- 3) Not every observed behavior is a warning sign, but vigilance, observance, and communication with the clinical team can potentially allow for interventions that can halt an emerging problem. What types of behaviors might represent negative changes to baseline behavior that should be discussed with treatment providers?
- 4) There will be times when a Case Manager is confronted with an acute and unexpected crisis in the field. What local protocols, emergency services, and response systems does your team need to know in order to address these crises?

Case Management Integration with Primary Care

What's in This Chapter?

Once a formerly homeless Veteran obtains stable housing, a number of previously unknown and unaddressed health conditions may surface. When a homeless Veteran enters the HUD-VASH program, it is entirely possible that he or she may have limited or no experience accessing civilian Veterans Administration (VA) health care, civilian primary care, and/or non-acute ambulatory care.

In this chapter you will learn about medical conditions associated with homelessness, clinical resources available through the VA, and strategies for communicating with clinical providers.

After reading this chapter, you should be comfortable identifying early warning signs and symptoms and helping Veterans navigate the healthcare system.

Overview

In many ways, keeping homeless Veterans in housing is as challenging, if not more so, than placing them. Drug and alcohol relapses, relationship problems, mental health issues, difficulty managing finances, and other day-to-day challenges can make housing maintenance a daunting task, and one in which HUD-VASH Case Managers play a critical role. However, it is important that this role not be viewed in isolation of other VA resources that can also advance the shared goals of stabilizing clients in permanent supportive housing.

In this chapter, we review

- medical complications associated with homelessness and how these issues often present and translate into health care needs;
- programs and initiatives within VA that may serve as resources for Case Managers, specifically Patient Aligned Care Teams (PACT), Primary Care–Mental Health Integration, and telehealth case management;
- key observations, signs and symptoms that, if noticed by the Case Manager, might indicate something of clinical significance; and
- best approaches for integrating and communicating with Primary Care Provider teams within VA medical centers/CBOC's.

Considering the high prevalence of chronic diseases in this population, the often-deferred and/or often-delayed primary and preventive care services; the unavailability of health care while homeless; and the ongoing role health care plays in helping individuals stay in permanent housing, the role of the Case Manager is critically important. Indeed, community-based case management provides a unique opportunity to identify risk factors, look out for signs and symptoms, raise concerns, and facilitate care of un- and undertreated medical and mental health conditions that could, if untreated, precipitate a return to homelessness.

CASE MANAGERS: KEY POINTS TO REMEMBER

Availability = Demand	Among HUD-VASH clients, many medical conditions may have gone untreated for extended periods of time. Unstable shelter, active use of drugs or alcohol, and competing medical needs often obstruct medical care. Once stable housing is obtained, there is often a pent-up demand for medical care.
Limited experience with self-advocacy	When a Veteran is overwhelmed by the system and/or physical or mental health issues, medical treatment priorities, as determined by health care providers, may not always reflect the needs and priorities of the Veteran. This may result in fragmented care and dissatisfaction.
Triage dilemma	Many unattended medical needs are associated with not having a regular source of care (Gallagher et al, 1997). When the Veteran then enters into the health care system, these multiple morbidities (mental illnesses, substance use, and acute and chronic medical problems) often create a triaging dilemma.
A stable environment can become a medically permissive one	“Housing First” models, where the receipt of stable housing is used as a vehicle, not a prerequisite, for achieving recovery goals, mental health services (if accepted), and economic support/self-sustainment, may require more assertive efforts to provide integrated and comprehensive care, particularly if stable housing makes it easier or safer to use drugs or alcohol at pre-homeless levels (Kertesz et al, 2009).
Unaccustomed to a preventive care lifestyle	Case Managers should take any opportunity to provide preventive care, engage the Veteran in behavioral changes that promote recovery goals, and de-habituate dependence on emergency services for medical care.
Unfamiliarity with health care system in general or with civilian health care providers	When a homeless Veteran enters HUD-VASH, it is entirely possible that he or she has limited or no experience accessing civilian VA, civilian primary, and/or non-acute ambulatory care. Veterans may not know what to expect, what is available, or what they may need.

Medical Complications of Homelessness

The average age at death for a homeless person is 47. Cancer and heart disease are the most common causes of death for the 45-64 year age group—a rate that is three times as high as that of the general population (Brickner et al, 1990). Homeless individuals in a younger demographic are more likely to die from infections, such as HIV/AIDS, or from trauma.

While there are many conditions, both acute and chronic, that threaten the health and well-being of

the homeless population, in general, the relationship between health and homelessness has been described within three contexts:

- Medical issues that precede and contribute to homelessness;
- Medical problems that are complications of homelessness; and
- Illnesses or conditions that are harder to treat or manage because of the patient’s itinerancy (Hwang et al, 1997).

MEDICAL COMORBIDITIES AND HOMELESSNESS

Conditions that precede, accelerate, or contribute to homelessness	<ul style="list-style-type: none"> ▪ Mental illnesses such as depression, schizophrenia, and bipolar disorder have long been reported as precipitants of homelessness (Institute of Medicine, Committee on Health Care for Homeless People, 1988) ▪ Drug and alcohol addictions (Jenks, 1995)
Conditions that are consequences of homelessness	<ul style="list-style-type: none"> ▪ Frostbite, trench foot, hypothermia, hyperthermia as results of exposure to the elements; often, these are exacerbated in intemperate zones when shelter demand exceeds capacity ▪ Parasitic infestations (scabies, bed bugs, lice, fleas) ▪ Increased exposure to transmission of airborne illnesses, especially tuberculosis, in overcrowded shelter conditions ▪ Weakened immune system function ▪ Increased risk of trauma (women are particularly vulnerable) (Kushel et al, 2003).
Conditions that are complicated by homelessness	<ul style="list-style-type: none"> ▪ Chronic diseases that require continuous monitoring and medication, such as diabetes (managing insulin-dependent diabetes while living in a dusk-to-dawn emergency shelter presents significant obstacles, not only in storing and securing medications, but also in managing multiple injections in the context of an unstable, erratic, and usually suboptimal food availability) ▪ Wound care: wound care is seriously compromised by inadequate hygiene in many sheltering arrangements as well as by the dependent edema that is a result of prolonged standing and walking

Unsurprisingly, homeless persons also utilize acute level health services at very high rates. In one survey, over 40% had used the emergency department at least once for care in the previous year; more disturbingly, 7.9% accounted for 54.5% of all visits (Kushel et al, 2002). In a national survey of homeless persons, one out of four indicated that they had been hospitalized annually (Kushel et al, 2001) and, in a study of homeless persons who accessed New York City hospitals, their average length of stay was 36% longer per admission than non-homeless individuals (Salit et al, 1998).

Indeed, previous research has consistently shown that unstable sheltering arrangements (i.e. residing in an emergency shelter or in an unsheltered

arrangement) are associated with high rates and inappropriate use of emergency departments (Kushel et al, 2002; O'Toole et al, 1999a; O'Toole et al, 1999b). In contrast, homeless persons in more stable sheltering arrangements are 2.4 times more likely to access care and receive care for chronic medical problems (O'Toole et al, 1999b).

As part of the benefits and opportunities afforded by permanent supportive housing, Case Managers can help Veterans

- learn to navigate the health system,
- advocate for their own ongoing care needs,
- transition from reliance on acute and emergency services to use of primary care, and

- engage in preventive care and chronic disease management.

Navigating the Health Care System: The Role of Primary Care

Primary care, and, specifically, primary care tailored to the needs of homeless or formerly homeless persons, provides a unique opportunity to comprehensively address some of the service gaps and vulnerabilities in homeless health care. It also provides a platform from which to engage homeless persons in an array of services over a continuum of time and needs. However, long-term homelessness (>2 years), competing needs, such as food, clothing, and finding shelter, and social isolation are all associated with not having a regular source of care (Gallagher et al, 1997). Additionally, multiple morbidities common among homeless persons, including mental illnesses, substance use, and acute and chronic medical problems, often create a triaging dilemma, whereby care may be fragmented and conditions not prioritized to reflect the priorities and preferences of the patient. This also can override any opportunity to provide preventive care and engage the person in behavioral changes.

As a result, when a homeless Veteran enters into HUD-VASH housing, it may be entirely possible that he or she has limited or no experience accessing

primary and/or nonacute ambulatory care and may not necessarily know what is available or what they need. This is obviously important when considering

- the high prevalence of chronic diseases in this population;
- the often deferred and delayed primary and preventive services not available while homeless and;
- very importantly, the ongoing role health care plays in helping individuals stay in permanent supportive housing.

Clinical Services and Resources within VA

Knowing where to go when advocating for a client, and knowing what clinical resources are available when problems arise, is clearly essential in the case management of at-risk HUD-VASH clients. Aligning the resources and services of VA with the health care needs of your clients can advance your shared recovery goals.

There are several initiatives within VA primary care that are available, or are being developed, that aim to improve access and coordination of care within VA. Some of them include the patient centered medical home or PACT (Patient Aligned Care Teams), the Integrated Primary Care-Mental Health initiative, and the CCHT/Telehealth program.

WORKING WITH PRIMARY CARE

RESOURCE/ COMPOSITION	OBJECTIVES	REFERRAL/ CONTACT
<p>PACT (PATIENT ALIGNED CARE TEAM)</p> <ul style="list-style-type: none"> ▪ 1-3 primary care providers (PCP's), a team RN, LPN, health technicians, nursing assistants ▪ Augmented by social workers, nutritionists, pharmacists, behavioralists, etc. 	<ul style="list-style-type: none"> ▪ Provide comprehensive, continuous, and coordinated care to Veterans ▪ Coordinate chronic disease management, improve treatment outcomes ▪ Serve as a first stop for urgent or emergent medical needs, thereby reducing emergency department visits and preventable hospitalizations ▪ Increase patient and staff satisfaction ▪ Engage client in primary care 	<p>All HUD-VASH clients must be linked to a PACT.</p>
<p>It is critical that the HUD-VASH client is assigned to one of these PACT teams and that team is used as a touchstone for engaging a client in primary care, coordinating any chronic disease management, and using as well as using it as a first stop access point for any urgent or emergent needs</p>		
<p>PRIMARY CARE— MENTAL HEALTH INTEGRATED CARE</p> <p>Care teams typically include social workers, psychologists, and sometimes psychiatrists</p>	<ul style="list-style-type: none"> ▪ Embed mental health care teams in Primary Care ▪ Increase the accessibility and availability of mental health services within VA, especially for individuals with specific, time-limited, non-severe mental health presentations (depression, anxiety) ▪ Eliminate traditional referral process ▪ Provide an outlet for individuals who feel stigmatized seeking mental health care through traditional channels ▪ Engage treatment-resistant clients ▪ Introduce individual to time-limited cognitive behavioral therapy ▪ Facilitate determination of most appropriate treatment with primary care and mental health team 	<p>Accessing this resource can typically be either directly with that provider team or via the assigned PACT team</p>
<p>CASE MANAGEMENT/ TELEHEALTH</p> <p>RN-level case management and home-based telehealth technology</p>	<ul style="list-style-type: none"> ▪ Use technology to provide ongoing monitoring and assessment of chronic conditions ▪ Intensive monitoring can inform and modify care plans before conditions worsen to the point of needing to go to the emergency department or to be hospitalized. ▪ Equipment conveys health information electronically; RN follows up with patient prior to patient becoming symptomatic or deterioration of condition 	<p>Patients with difficult-to-manage chronic diseases such as diabetes, congestive heart failure, etc.</p>

Communicating with the Clinical Team

It is uniformly accepted that good communication is critical to effective, timely, and coordinated care. However, often the professional and service-driven “silos” in which we operate make this communication difficult. Yet, the Case Manager can always work to improve communication, as, ultimately, this will better serve the Veteran.

First, HUD-VASH Case Managers are part of the clinical team and have an integral role in the care of the Veteran. Being part of the clinic team means that releases of information or other restrictions are not needed in conveying information to and from the provider and PACT team.

Second, it is critical to reiterate that identifying contacts within the PACT or other clinical services team, and establishing channels for communication, should take place before a crisis occurs. Typically, the RN on the PACT team is a good point of contact (s/he is often more readily available for consult than the lead physician). Alternatively, some PACT teams may instead have the primary care provider (PCP) or health tech as the point of contact.

There are several ways to establish regular contact with the clinic team. Meeting with the team as part of their weekly meeting or daily clinic huddle is another opportunity to convey any concerns or update them on a client’s progress. Another approach chosen by some Case Managers is to accompany the patient to the clinic visit. This provides an opportunity for the Case Manager to both advocate for the Veteran and to listen to the primary care treatment plan. When members of the clinic team meet with the Veteran, it also increases the Veteran’s sense of treatment unity and cooperation, enhancing trust and conveying the sense that there truly is a team working on behalf of the individual.

None of these approaches is exclusive of another, and they often complement each other. The key is to establish what communication channel works best for everyone in advance of a crisis, typically by meeting with the team and asking which approach is mutually convenient.

Third, it is important to feel comfortable conveying not only direct observations and reported symptoms, but also less concrete concerns. Again, the HUD-VASH Case Manager is in the unique position of being able to observe the client in contexts that are not readily apparent during a clinic visit. Using this vantage point to observe, gather data, and form impressions of the Veteran’s functioning that may contribute to the care team’s ability to assess symptoms and create treatment plans is invaluable, as it brings to the clinical encounter a perspective not typically available.

Finally, it is also important to recognize that functional communication is a two-way process and that Case Managers may be asked by the care team to follow up with the patient regarding care plans or assessments, emphasize actions steps or behaviors that were encouraged in the clinic appointment, or facilitate compliance with a given treatment or medication.

Eliciting Clinically Relevant Information—What to Ask your Client

Many behaviors and symptoms can suggest more serious underlying problems that, if left untreated, could lead to worsening mental and physical health, precipitate a relapse, and or ultimately jeopardize one’s ability to stay housed. Case Managers are often in a unique position to ask about and observe behaviors that clients might not otherwise find significant or feel comfortable reporting. Case Managers should remain vigilant and in close communication with the primary care team when

- **The client reports feeling down, depressed, anxious or becomes socially withdrawn.** These may all be signs and symptoms of an underlying depression or anxiety disorder that may become more evident when the client does not have to navigate soup kitchens, emergency shelters and other programs or offices to meet their daily sustenance needs. Alternatively, the Case Manager might observe the client present with pressured speech, report little to no sleep, and/or speak in grandiose terms. This could suggest hypomania as part of bipolar disorder.

- **The client complains of pain.** This is particularly common when a Veteran with a long-term drug or alcohol abuse pattern becomes sober and no longer has the effects of substances to mask or block the pain or injury. It is important to be vigilant and responsive, as untreated pain can often lead to relapse, and there are a variety of pain management treatments available, including non-pharmaceutical alternatives.
- **The client skips or stops taking medication.** Many conditions require chronic medication dosing in order to be controlled, yet it is often difficult to convey these physiological reasons for compliance. This is especially true when the client may not recognize an immediate or direct benefit from the medication. Some medications must build up in a client's system in order to have a noted effect, particularly antidepressants; other medications have subtle or unrecognized effects. As discussed earlier, the client may be trying to alleviate medication side effects (for example, diuretics cause increased urination and may cause erectile dysfunction). Cost may also be an issue, especially if full VA benefits are still pending; when certain drugs are not on the VA formulary, pharmacy access or co-pay could be a barrier to treatment adherence.
- **The client reports hypersomnolence, lack of energy, and/or constant fatigue.** While these symptoms can be associated with a depressive disorder or other mental health condition, they can also be associated signs and symptoms for conditions like congestive heart failure, anemia, substance abuse relapse, or endocrine disorders such as hypothyroidism or new onset/poorly controlled diabetes. Often, this will require a medical evaluation, including bloodwork. The sooner the primary care team is aware of presenting symptoms, the sooner the work-up can begin.
- **There are significant changes to eating habits or diet.** When a Veteran locates and receives permanent housing, it also represents a daily lifestyle change with decreased emphasis on walking and transit, greater food security and autonomy, and decreased reliance on soup kitchens for support. Alternatively, weight loss and/or poor appetites may suggest limited availability or access to food and income resources, depression or anxiety, acute conditions such as a cancer, or chronic medical conditions such as liver disease and cirrhosis. While the client may not think much of these changes, a clinical work-up can rule out more serious explanations and to address potential complications.
- **The Veteran regularly misses appointments or meetings.** While occasional forgetfulness may be expected, a developing pattern of this may suggest a downward trend in motivation or treatment engagement. This relationship is particularly well-established with drug or alcohol abuse relapses, when, often, the client starts missing meetings, avoiding the Case Manager, or ignoring the PCP or other team members. If the Veteran is in the throes of a relapse, he or she may not be fully cognizant of the threats to health and housing constituted by this behavior.
- **There is difficulty engaging the Veteran in health maintenance and preventive health care.** For many Veterans, in their "former" unsheltered lives, going to a clinic or hospital is only done in the case of sickness or injury. Primary and preventive care was not a priority, especially in the context of also trying to secure housing, get food, stay safe, etc. Now, with permanent, supportive housing, many homeless Veterans need to rethink what seeking health care means. Case Managers should advocate, encourage, and facilitate interaction with the primary care team that includes screening for high blood pressure, diabetes and other chronic diseases; screening for tuberculosis, colon, prostate, breast, and cervical cancers; immunizations and vaccinations against seasonal influenza, H1N1, tetanus, and other conditions.

KEY POINTS

- Releases of information or other restrictions are not needed when conveying information among provider, PACT team, and Case Manager
- Establish communication before a crisis occurs
- Meet with the PACT team or accompany client to clinic visit to further establish rapport
- Feel comfortable communicating observations, symptoms, and concerns
- Work with PACT team to also understand how you can help support them
- Be proactive—monitor, observing, and routinely ask about changing signs, symptoms, and behaviors
- Trust your instincts—use what may not seem or feel right as a starting point for further investigation

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Test Your Knowledge!

Quick Check: Answer "true or false" to the following statements to check your knowledge about integrating your work with primary care.

- 1) The average age of death for a homeless person is 47.
- 2) The rate of death from cancer and heart disease for Veterans 45-64 years of age is three times as high as that of the general population.
- 3) Health care provides the platform on which to engage homeless persons in an array of services over a continuum of time and needs.

- 4) All HUD-VASH participants must be linked to a Patient Aligned Care Team (PACT).
- 5) PACTs serve as a first stop for urgent or emergent medical needs.
- 6) TELEHEALTH is a hot line for Veterans experiencing medical emergencies.
- 7) Releases of information are needed for conveying information to and from the provider and the PACT team.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) The relationship between health and homelessness has been described within three contexts: medical issues that precede and contribute to homelessness; medical problems that are complications of homelessness; and illnesses or conditions that are harder to treat or manage because of the patient's moving from

place to place. What are some examples of each of these?

- 2) Multiple morbidities including mental illnesses, substance use, and acute and chronic medical problems, often create a triaging dilemma, whereby the care may be fragmented. How can your team prioritize the preferences of the Veteran in these instances?
- 3) The professional "silos" in which providers operate can make communication difficult. Further, who to talk to and when can be elusive and frustrating. What steps can your team make to improve and enhance communication among all care providers to better serve Veterans?
- 4) Many behaviors and symptoms can suggest more serious underlying problems that, if left untreated, could lead to worsening mental and physical health. What are some of the things to watch for to prevent a worsening in health?

Considerations for Homeless Veterans Enrolled in HUD-VASH

What's in This Chapter?

Trauma-Informed Care is an important consideration for Case Managers as combat stress and trauma reactions are especially prevalent. The more providers are aware of trauma and its impacts, the better able they are to encourage appropriate treatments and promote recovery.

In this chapter you will learn

- How to recognize trauma,
- Its impacts,
- Psychiatric disorders that can directly arise from trauma, and
- The differences between Trauma-Informed Care and Trauma-Specific Treatment.

After you read this chapter, you will be able to incorporate Trauma-Informed Care into your approach to serving Veterans in HUD-VASH

What is it and why does it matter?

In the past decade, the term “trauma-informed care” (TIC) has become a central component of treatment services for all vulnerable populations, including Veterans and the homeless. As reactions to trauma involve a host of behavioral, psychological, and physical reactions, acknowledging it can have important impacts on treatment planning and delivery. When Case Managers are aware of trauma—and familiar with the intentional and subconscious ways people may cope—the more promptly and comprehensively they can respond.

“Trauma” refers to the experience, threat, or witnessing of physical harm (American Psychiatric Association, 2004). It includes various types of

experiences such as military combat, military sexual trauma, terrorist attacks such as 9/11, serious car accidents, natural disasters (hurricanes, tornadoes), major medical illnesses and injuries, childhood physical or sexual abuse, assault and violence. Most Americans (about 61% of males and 51% of females) experience one or more traumas during their lifetime (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005), but it is important to remember that trauma is as universal as it is common—and potentially even more so—in other parts of the world (Kessler, 2000). Beyond the risk for trauma that is inherent in interactions with other people and the environment, there are also particular stressors related to military service.

“Trauma, especially when untreated, can have severe negative impacts on a person’s physical and emotional well-being. Trauma has been linked to hallucinations and delusions, depression, suicidal tendencies, chronic anxiety, hostility, interpersonal sensitivity (i.e. poor “social skills”), somatization (i.e. “chronic fatigue syndrome”), eating disorders, and dissociation.” (Witness Justice, 2010).

Trauma is important because it can have varied and major effects on an individual’s functioning. Trauma victims are at a much higher risk for co-occurring mental health and substance use disorders, violence victimization and perpetration, self-injury, and other coping mechanisms—all with devastating human, social, and economic consequences. Trauma has been linked to social, emotional, and cognitive impairments, disease, disability, serious social problems, and premature death (Witness Justice, 2010).

There are also important contextual factors that can impact how a person responds to trauma. These include gender differences, cultural sensitivities or traditions, response delays (i.e., some people may

react months or years after the traumatic event), single versus repeated traumas (how many times it occurred), age at time of trauma (child versus adult), the biological impact of trauma (mind-body connections), and how others reacted (family, community, colleagues, and society at large). Thus, it is important to remember that, while certain types of traumas may appear similar enough to categorize

(loss of a soldier in combat; car accidents), each event may have quite a different impact depending on the individual and the context.

There are several key psychiatric disorders that can directly arise from trauma, typically in a minority of clients. These are outlined below.

TRAUMA-RELATED PSYCHIATRIC DISORDERS	
MENTAL ILLNESS	CHARACTERISTICS
<p>ACUTE STRESS DISORDER</p> <p>(Occurs during, or up to 4-6 weeks following, trauma)</p>	<p>Symptomatology varies, but may include</p> <ul style="list-style-type: none"> ▪ Sense of numbing or detachment ▪ Reduced awareness of surroundings, or being in a “daze” ▪ Difficulty recalling important aspects of the trauma ▪ Feelings of being unreal ▪ Anxiety ▪ Avoiding reminders of the trauma ▪ Re-experiencing the trauma through flashbacks or nightmares ▪ Significant decline in functioning
<p>POST-TRAUMATIC STRESS DISORDER (PTSD)</p> <p>(Diagnosed only four weeks or more after the trauma, thus indicating a persistence of trauma-related symptoms that do not diminish with time)</p>	<p>Includes many symptoms associated with acute stress disorder, as well as others. In general, the symptoms fall into three main categories:</p> <ul style="list-style-type: none"> ▪ Re-experiencing the trauma, including flashbacks, nightmares, and/or intense physical and emotional “triggering” when reminded of the trauma) ▪ Avoidance of reminders of the trauma ▪ Intense arousal (e.g., difficulty sleeping, anger outbursts, startle reactions)
<p>DISSOCIATIVE DISORDERS</p>	<ul style="list-style-type: none"> ▪ Occur in small percentage of the population after exposure to extreme and chronic trauma, such as repeated childhood or prisoner-of-war trauma experiences ▪ Marked by changes to consciousness, memory, identity, or perception ▪ Client may have major memory gaps or feel unreal ▪ In severe cases, dissociative identity disorder may be present, characterized by the presence of “alters” (different personalities) within the self. The client may be unaware, or unable to control, switching between them.

A major element of trauma-informed care is to educate all staff on the importance of trauma. According to the National Center for Trauma-Informed Care,

“When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services.”

CASE MANAGEMENT SPECIFICS FOR TRAUMA-INFORMED CARE

- Train all staff in basics of trauma education (rates, impact of trauma, how to interact with traumatized clients)
- Take steps to avoid re-triggering trauma (e.g., restraints, isolation, coercion)
- Create advance directives of how to manage intense emotions (i.e., concrete plans of what to do if the client becomes agitated, such as who s/he will talk to, what strategies help to calm the person, etc.)
- Elicit input from survivors of trauma on how to design services that are trauma-sensitive
- Focus on dynamics that empower the traumatized client, such as offering choices, expressing compassion, listening
- Learn strategies for helping clients realize and understand how some behavioral patterns may have developed from trauma
- Modify policies to respect trauma sensitivity (e.g., a client may need lights on at night in residential treatment)

Case Example

Jason is a returning Veteran from OIF, who is currently in residential care at VA due to homelessness and multiple psychiatric problems. He struggles with substance dependence that arose about six months after returning home from Iraq (primarily alcohol, but also misuse of prescription medications).

Jason was exposed to multiple traumas during his deployment, including seeing a fellow soldier, Bill, die in a blast from an improvised explosive device. Jason was nearby and was almost killed himself. He reports that he has felt “dead inside” ever since losing Bill, who was a good friend. While still deployed, he volunteered for the most dangerous assignments, not caring if he lived or died. Upon his return, his wife and children seemed afraid of him, as he would burst into angry episodes over small things, such as someone not putting things away correctly. Before this deployment, Jason had been an easy-going, quiet person, but they felt they barely recognized him now. His wife told him to get treatment or she would leave him; Jason refused and moved out. Without a job, he ended up on the streets, where he became a low-level worker for a drug dealer to try to earn some money. An outreach worker from VA talked him into trying to get into VA care. During an intake interview, he was diagnosed with posttraumatic stress disorder, substance dependence (alcohol), dysthymia, and intermittent explosive disorder. He became increasingly isolated and withdrawn, feeling hopeless that anything could make a difference.

Now in residential care at the VA, he is required to attend treatment as a condition of receiving temporary housing. While initially withdrawn, distrustful, and somewhat paranoid, as he settled in and became more comfortable, he began to open up. He started sharing a bit in groups and was able to connect with a counselor whom he trusted. The counselor helped Jason understand the impact of trauma on his life, and helped him see how his misuse of alcohol and prescription medications had been a way to try to cope with trauma-related symptoms. He says,

“My counselor got it, even when I didn’t, that trauma had played a huge role in how I ended up homeless and at the bottom. I kept blaming myself, but my counselor helped me see that the traumas I had been through had festered inside me and affected everything I did, yet I never dealt with them or even acknowledged how important they were. My counselor was kind, and moved slowly, pacing to what I was able to do at any time and never pushing or judging me.”

Jason ultimately entered individual treatment with a VA therapist specializing in PTSD care, with whom he continued to work on his substance dependence. He gradually learned new coping skills and engaged in family therapy. Ultimately, about three years after he left home, he was able to re-unite with his family and move back in with them.

CASE QUESTIONS:

- 1) How did trauma play a role in Jason's problems?
- 2) What helped him to recover?
- 3) What elements of trauma-informed care do you notice in his treatment?
- 4) Are there other things his counselor could have done to create a trauma-sensitive treatment experience?
- 5) When you work with clients, how much do you practice trauma-informed care? What could you do differently to increase this aspect?

Case discussion: Jason is typical of some returning Veterans in that he was exposed to trauma during a deployment and developed a substance use disorder after coming home. His family problems, homelessness, and multiple psychiatric problems are also representative of some of the more severe clients. His hopelessness, sleep problems, difficulty taking care of himself, and downward spiral are all typical trauma-related problems that are magnified in the context of substance dependence and other psychiatric disorders. Yet Jason is a success story in several ways:

- A VA outreach worker was able to engage him into treatment, even amid Jason's significant distrust and isolation.
- Jason's counselor used a trauma-informed approach focusing on building trust, pacing, and education about trauma and related problems.
- Jason was referred to a VA PTSD specialist for treatment of the PTSD, and, eventually, when ready, to family therapy to help re-unite him with his family.

In sum, a trauma-sensitive approach helped Jason engage in recovery and, in conjunction with specialized treatment for PTSD, substance dependence, homelessness, and family problems, he was able to make significant progress.

Trauma-Informed Versus Trauma-Specific Services

It is important for the Case Manager to be able to distinguish between trauma-informed care considerations and trauma-specific mental health interventions. As the Case Manager, your primary responsibilities are to avoid ruling trauma out as a possibility, even if unshared or uncommunicated; to view symptom and behavior changes in light of potential traumatic responses; and to be able to make pro-active, prompt referrals for Veterans who need more targeted evaluations and treatment.

Case Managers offer trauma-informed services; clinicians and mental health professionals offer trauma-specific interventions. The program goal should be for all counselors to be trauma-informed, while specific members of the treatment team will specialize in trauma-specific interventions.

- **Trauma-informed services** are grounded in basic principles of awareness. All HUD-VASH staff should be knowledgeable about trauma symptoms and the impact of trauma on clients' lives. Case Managers and other staff should be able to implement basic skills such as grounding, trauma screening, and to know how and when to refer clients out for specialized help. An example of a model that is used in VA for trauma education is Seeking Safety [Najavits].
- **Trauma-specific services** are administered when a smaller number of staff become trauma-competent, in that they are able to effectively treat trauma-related disorders, such as PTSD, using evidence-based models. Some of these interventions require specific training in order to perform them with adequate fidelity.

Examples of trauma-therapy models that are used in VA include Prolonged Exposure (Foa, 2007), Cognitive Processing Therapy (Resick, 2007), and Eye Movement Desensitization and Reprocessing (Shapiro, 1999).

Without specific training, program staff can sometimes do harm if they try to treat trauma-related disorders without adequate preparation and training. “First, do no harm” remains the central principle of all treatment. Thus, although trauma-specific therapy models can be very helpful (they are PTSD evidence-based therapies), they require specialized training. For example, in VA, prolonged exposure therapy is often used for PTSD treatment, yet requires extensive training, monitoring, and careful implementation. The Case Manager should prioritize linking a Veteran who may be suffering from trauma response disorders with a clinical evaluation, and should support the clinician’s treatment plan.

Trauma-Informed Care Considerations

Style of interaction

A key element of trauma-informed care is interacting with the client in ways that promote the best response possible. According to Walser, within the therapeutic relationship, it may also be important to place less emphasis on confrontation and more on tolerance of the problem. Many individuals who treat substance use disorders can use a harsh confrontational style. They can draw the line in a very specific way and say things like, “You need to get yourself together,” or “You need to stop doing this.” When counseling clients who are working through traumatic stresses, it is important to remember that the trauma may have occurred under conditions of harsh confrontation, so that the intervention itself might trigger the very responses it is aimed to alleviate. It is important to consider the style of interaction in order to avoid problems within the therapeutic relationship and avoid treatment roadblocks.

On the other side of a confrontational style is one that incorporates misguided sympathy. There are clinicians and therapists who feel that their patients have had too many traumas, and over-sympathize

with them. It may be difficult for some therapists to hold clients responsible for doing homework or engaging in the responsible actions necessary for working through triggers and toward recovery.

If harsh confrontation is on one end of the spectrum, and misguided sympathy is on the other, HUD-VASH team members may have most success using a soft confrontational style that expresses confidence in the Veteran’s ability to take responsibility for parts of his or her own recovery. (http://www.ncptsd.va.gov/ptsd101/modules/Walser_SA_Transcript.pdf)

The importance of culture and gender

It is also important to be sensitive to how culture and gender may play a role in how trauma is perceived, addressed, and treated. For example, culture and gender may affect whether an individual is able to identify trauma symptoms as “legitimate” (e.g., in some cultures psychological problems are considered more taboo to discuss than in others); may affect how symptoms are expressed (e.g., as emotional versus more physical in nature); may affect co-morbidity (e.g., the likelihood of using certain substances as ways of coping with trauma symptoms); and may affect treatment response (e.g., whether the counselor is aware of cultural and gender subgroup issues). Thus, counselors are encouraged to seek training in cultural, diversity, and gender-based issues so as to provide the most compassionate care possible to Veterans who are often of various different subgroups.

KEY ELEMENTS OF TRAUMA-INFORMED CARE FOR COUNSELORS

- Anticipate proceeding slowly with a client who is diagnosed with or has trauma-related symptoms. Consider the effect of a trauma history on the client's current emotional state, such as an increased level of fear or irritability.
- Develop a plan for increased safety where warranted.
- Establish both perceived and real trust.
- Respond more to the client's behavior than to his/her words.
- Limit questioning about details of trauma.
- Recognize that trauma injures an individual's capacity for attachment. The establishment of a trusting treatment relationship will be a goal of treatment, not a starting point.
- Recognize the importance of one's own trauma history and counter-transference.
- Help the client learn to de-escalate intense emotions.
- Help the client to link trauma and substance abuse.
- Provide psychoeducation about trauma and substance abuse.
- Teach coping skills to control trauma symptoms.
- Recognize that trauma/substance abuse treatment clients may have a more difficult time in treatment, and that treatment for trauma may be long term, especially for those who have a history of serious trauma.
- Help the client access long-term treatment, if needed, and refer to trauma experts for trauma exploratory work.

**Reprinted from SAMHSA's Treatment Improvement Protocol: Trauma and Substance Abuse (in press). Consensus panel chairs: Lisa M. Najavits, PhD and Linda B. Cottler, PhD, MPH*

Trauma Related Resources

- VA National Center for PTSD (<http://ptsd.va.gov>). This site is provided by the US Department of Veterans Affairs to offer education and materials related to trauma and PTSD. It also includes the PILOTS database (the world's largest literature base on PTSD and related disorders).

- Witness Justice (<http://witnessjustice.org>). Created by survivors for survivors. Their mission is to provide support and advocacy for victims of violence and trauma.
- National Center for Trauma-Informed Care (<http://mentalhealth.samhsa.gov/nctic>). Site developed by the Substance Abuse Mental Health Services Administration to provide resources for trauma-informed care.
- National Child Traumatic Stress Network (<http://www.nctsnet.org>). Joint effort by university, government, and community agencies to provide materials, education, and resources to improve care for traumatized children and families.
- International Society for Traumatic Stress Studies (<http://www.istss.org>). Professional society devoted to science, practice, and policy related to trauma and PTSD.
- International Society for the Study of Dissociation (<http://www.issd.org>). Professional society devoted to science, practice, and policy related to trauma and dissociation.
- Sidran Foundation (<http://www.sidran.org>). Provides information related to recovery from traumatic stress (including PTSD), dissociative disorders, and co-occurring issues, such as addictions, self injury, and suicidality.
- National Resource Center on Domestic Violence (<http://www.vawnet.org>). An online resource for advocates working to end domestic violence, sexual assault, and other violence.
- EMDR International Association (<http://www.emdria.org>) and EMDR Humanitarian Assistance Program (<http://www.emdrhap.org>). The first of these, EMDRIA, is a membership organization of mental health professionals dedicated to the

highest standards of excellence and integrity in EMDR (eye movement desensitization and reprocessing therapy for trauma and PTSD). The second, EMDRHAP, is a global network of clinicians who travel anywhere there is a need to stop suffering and prevent the after-effects of trauma and violence. Their primary focus is on training local therapists within crisis or underserved communities to treat trauma using EMDR (Eye Movement Desensitization and Reprocessing).

- Seeking Safety (<http://www.seekingsafety.org>). Offers resources on trauma and substance abuse, including general information as well as material to implement the Seeking Safety model.

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Test Your Knowledge!

Quick Check: Answer "true or false" to the following statements to check your knowledge about Trauma-Informed Care.

- 1) Trauma is common.
- 2) Trauma refers to the direct experience of physical harm. Experiences in which physical harm is witnessed or threatened are referred to as "secondary trauma."
- 3) Trauma victims are at a much higher risk for co-occurring mental health and substance abuse disorders.
- 4) Psychiatric disorders can directly arise from trauma.
- 5) Only senior level staff should be educated on the importance of trauma.
- 6) Counselors who interact with traumatized clients should limit questioning about details of the trauma.
- 7) Once a Case Manager is trauma-informed, she or he can provide trauma-specific treatment.
- 8) Trauma-informed care also emphasizes sensitivity to culture and gender.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) Psychiatric disorders that can directly arise from trauma include acute stress disorder, post-traumatic stress disorder, and dissociative disorders. How are these disorders similar and/or different?
- 2) What are some specific examples of Trauma-Informed-Care?
- 3) Review the case example on page 129 and answer the questions that follow. Then review the case discussion to see how your responses align with those in the *Resource Guide*.
- 4) What are some of the differences between trauma-informed services and trauma-specific services?
- 5) A number of trauma related resources are available for HUD-VASH teams. What are they and which will you utilize in your program?

Supported Employment and Supported Education for Homeless Veterans in HUD-VASH

What's in This Chapter?

HUD-VASH teams have the opportunity to facilitate employment and education goals for the Veterans they serve. In some areas, these services are provided by specialized practitioners, so the first step is always to link Veterans to these resources. However, if these resources aren't available, Case Managers will need to take the lead on supporting Veterans' education and employment goals.

In this chapter you will learn

- What opportunities exist to address employment obstacles,
- Particular VA programs that assist in employment,
- The principles and practices of supported employment and education,
- Skills needed for assisting Veterans in pursuing employment, and
- Ways to support the educational goals of Veterans.

After reading this chapter, you will be able to promote the employment and education of Veterans on your caseload.

Introduction

As a Case Manager, you have the opportunity to strengthen the recoveries of homeless Veterans by offering supportive services in multiple domains. Your commitment to their housing stability also includes helping them develop and plan for increasingly independent and fulfilling lives. Part of this includes income and financial planning, job skills development, and other goals that are directly tied to supported education and employment goals.

As important as the Case Manager's role is, Supported Education and Supported Employment are specialized fields for practitioners, and so the first step is always to link your clients to these resources when possible. If dedicated resources aren't available, then your own ability to apply the principles outlined in this chapter will be very helpful to the Veteran. Regardless of whether you, or another provider, take the lead on supporting your client's education and employment goals, the guiding principle remains the same: everyone who wants to work or learn should be encouraged and supported in that endeavor, and you should draw on VA and community resources to help you provide that support.

PRIORITIES FOR HUD-VASH CASE MANAGERS WHOSE CLIENTS HAVE A GOAL TO WORK OR GO TO SCHOOL

- Acknowledge, believe in, and support an expressed desire to work or go to school
- Link clients to existing resources at VA
- Link clients to community resources
- Integrate the Veterans employment or education goal with their mental health team
- Serve as liaison for a working or matriculated Veteran with members of care team

Supported Employment

With increasing housing stability may come increasing opportunities to work and to enjoy the related material and psychological benefits. These

may be especially important, yet previously elusive, to Veterans who were homeless. As a Case Manager, you can encourage Veterans to seek employment or work toward educational goals; you also have an

opportunity to facilitate these goals. As you begin to think about your client’s education or employment goals, some issues will likely arise, as outlined below.

WHAT MIGHT CASE MANAGERS EXPECT FROM VETERANS WHO EXPRESS A DESIRE TO WORK?	
CHALLENGE	REFERRAL/OPPORTUNITY
<ul style="list-style-type: none"> ▪ Spotty or remote work history 	<ul style="list-style-type: none"> ▪ Skills assessments, even if not based on employment history, may highlight previously unidentified skills ▪ Specific work programs at VA can help establish a work history
<ul style="list-style-type: none"> ▪ Reluctance to try to work again if they have been unsuccessful in the past 	<ul style="list-style-type: none"> ▪ Mental health integration can help work through psychological barriers ▪ Transitional work and other programs may help build confidence ▪ Identification of what made those attempts unsuccessful (active addiction? No permanent residence? Uncontrolled symptoms?) and action plans to emphasize what is different this time
<ul style="list-style-type: none"> ▪ Prior criminal justice involvement or other gaps in employment histories 	<ul style="list-style-type: none"> ▪ Check out the Bazelon Center for Mental Health Law (http://www.bazelon.org/) to learn about what potential employers can and can’t ask about mental health history and/or prior problems with the law.
<ul style="list-style-type: none"> ▪ Limited resources to prepare for job search and competition, including unfamiliarity with technology (relevant for both job search and job skills), clothing and personal hygiene, interpersonal skills, paperwork or application difficulties, etc. 	<ul style="list-style-type: none"> ▪ State Department of Labor ▪ One Stop Career Centers ▪ Non-profits who offer clothing and support for people entering the workforce; for example, Dress for Success and Career Gear provide professional clothing free of charge (www.dressforsuccess.org, for women; www.careergear.org, for men). Career Gear even has a retention program focused on maintaining job skills and continuing professional development. It will provide interview suits from head to toe for disadvantaged job seekers. ▪ Investigate VFW or American Legion posts who may have special programs for helping with these issues
<ul style="list-style-type: none"> ▪ High job turnover/job maintenance problems 	<ul style="list-style-type: none"> ▪ Identification of what contributed to keeping jobs in the past; emphasize what is different now. Create action plans to address issues and provide follow-along support.
<ul style="list-style-type: none"> ▪ Difficulties interacting with co-workers or supervisors 	<ul style="list-style-type: none"> ▪ Social skills coaching ▪ Case Manager or Mental Health team consultation with employer, etc. ▪ When difficulties stem from military experiences and a feeling of being misunderstood or judged, linking the Veteran to positive supports with other Veterans, other individuals in recovery, and/or community supports may help (12-step programs, mental health support groups, Patriot Guard Riders, community sports, etc., or re-exploration of VA job programs)

(Chart continued on next page)

(Chart continued from previous page)

WHAT MIGHT CASE MANAGERS EXPECT FROM VETERANS WHO EXPRESS A DESIRE TO WORK?	
CHALLENGE	REFERRAL/OPPORTUNITY
<ul style="list-style-type: none"> Relapses or medical issues related to mental health status or substance use disorders 	<ul style="list-style-type: none"> Case Manager's continuous communication with integrated primary care and mental health team can prevent, explain, monitor, ameliorate effects of mental health/substance abuse relapses on job and on employer
<ul style="list-style-type: none"> Need to manage symptoms from either mental illness or side effects from medications while on the job 	<ul style="list-style-type: none"> Primary care and mental health involvement is key! Encourage Veteran to share job goals with staff during medication reviews, keep detailed notes of side effects, etc. Work with MH counselors and/or with Veteran on grounding and meditation techniques to assist with anxiety/flashback symptoms; encourage Veteran to use principles from therapy; help MH counselors understand problems to better plan interventions
<ul style="list-style-type: none"> Benefit deterrents 	<ul style="list-style-type: none"> Be knowledgeable; work through benefits discussions with Veteran. Get benefits counseling from the Social Security Administration or the Veterans Benefits Administration.
<ul style="list-style-type: none"> Need for reasonable job accommodations due to disability, illness, etc. 	<ul style="list-style-type: none"> Check out the Job Accommodation Network: www.askjan.org
<ul style="list-style-type: none"> Family care issues 	<ul style="list-style-type: none"> Case Manager can help with benefits (child care expense offset of income for benefit planning purposes); during voucher planning, live-in family caregivers may be eligible for inclusion in housing; aides for disabled or elderly individuals may also be included Social work and other resource referrals to help individuals plan day care, adult care, home health, etc.
<ul style="list-style-type: none"> Difficulty navigating logistics (transportation issues, etc.) 	<ul style="list-style-type: none"> When the Veteran's residence shifted and changed, he/she may have felt "able" to work in a variety of different places. However, this may have also exacerbated difficulties maintaining a regular job. A fixed residence may seem to limit possibilities: help Veteran consider employment opportunities when choosing a community in which to live (is community close to public transportation, what is available around those public transit lines, does the neighborhood itself have possibilities, etc.) Work with Veteran to learn and utilize public transportation, carpool, etc.

Although these barriers can be formidable, in the last thirty years, great strides have been made in the knowledge and application of interventions that contribute to successful work outcomes. The VA has embraced many of these principles and programs. HUD-VASH Case Managers can take advantage of

these VA programs on behalf of the Veterans they serve, and they can adopt many principles in their own interactions with Veterans. These opportunities to provide or to link Veterans to VA employment supports are described below.

VA RESOURCE GUIDE

PROGRAM	LOCAL AVAILABILITY	REQUIREMENTS
Vocational Rehab (Chapter 31)/ VetSuccess	http://www.vba.va.gov/bln/vre	<ul style="list-style-type: none"> ▪ Service-connected disability of at least 10% within 12 years of rating ▪ Honorable discharge
<p>After assessment and determination of an employment handicap, a vocational rehabilitation counselor will work with the Veteran to develop a suitable employment goal and a rehabilitation plan to achieve that goal. The plan will describe the services and resources the VA will provide to assist the Veteran in achieving his/her goals. Goals will involve one of five tracks of VA services including: (1) reemployment (with a former) employer; (2) direct job placement; (3) self-employment; (4) training or education to achieve employment goals; or (5) independent living services. The VR counselor or Case Manager will work with the Veteran to implement the plan.</p>		
Compensated Work Therapy (CWT) Program	http://www.cwt.va.gov/ LOCATIONS: http://www.cwt.va.gov/cwt/locations.asp	<ul style="list-style-type: none"> ▪ Service-connected disability ▪ Mental or physical impairment ▪ Substance abuse diagnosis in active recovery (abstinence) ▪ Clinical stability ▪ Referral is necessary—obtain someone privileged at a VAMC for vocational services
<p>The CWT program’s mission is to provide realistic and meaningful vocational opportunities to Veterans; encouraging successful reintegration into the community at the Veterans’ highest functional level. To achieve this mission, CWT staff will match an individual Veteran’s vocational strengths and areas of interest to employment opportunities with local businesses and industries in many occupational sectors. CWT programs develop an individual rehabilitation plan for each Veteran and provide a wide range of support services such as vocational case management and workplace supports to the Veteran at CWT locations.</p>		
Transitional Work (TW)	<p>Transitional Work (TW), a pre-employment vocational assessment and experience program that operates in the VA medical center and in local community businesses. TW participants are screened and assessed by vocational rehabilitation staff and matched to a work assignment for a limited time as deemed clinically appropriate. TW work assignments are not jobs that the Veteran competes for with the rest of the labor force. Rather, the job is typically arranged between the VAMC and the employer and the VA will fill the job with a rotating set of workers. The emphasis is more on paid employment activity rather than a competitive job in the traditional sense, with hourly payments made to the Veteran by the VA and not by the employer. Veterans participating in TW are not considered employees of the VA or the participating company, and receive no traditional employee benefits. Veterans at the work assignment are supervised by work site staff. The same job expectations are imposed on the Veteran as would be of non-CWT workers in the company. CWT work assignments can be considered to be a “temp to hire” program allowing a company to pre-screen Veterans, observing them in action before making a decision on whether to hire them permanently. CWT provides employers a source for temporary and permanent workers or a means for completing work on a piece rate or job rate basis.</p>	
Enrollment in Supported Employment Program	http://www.cwt.va.gov/locations.asp (Select the state and facility of interest; there will be information that indicates which programs are available at that location, and contact information.)	<ul style="list-style-type: none"> ▪ Psychosis or serious mental illness ▪ Need highest level of assistance and support
<p>In the SE model, the job is owned by the employee through a contractual arrangement with the employer, who pays the Veteran directly; SE follow-up may continue indefinitely, but generally participation and supports are phased out after the Veteran is able to maintain employment independently. CWT supported employment is modeled after the evidence-based approach called Individual Placement and Support (IPS) developed by the Dartmouth Psychiatric Rehabilitation Center and adopted for national roll-out in the VA in 2004. The VA SE model utilizes the fundamental principles of the IPS model, including integration of an employment specialist with the clinical team, rapid job development, placement based on client preferences and skills, and no mandatory pre-vocational assessment or work experience. SE is available to all regardless of prior work history or clinical status, support and follow-up is provided indefinitely and in varying intensities as needed, there is a very low caseload ratio for employment specialists, and specialists are expected to work closely with employers (when approved by the Veteran) for job development and problem solving including negotiation for accommodations. Supported employment is designed to be delivered by a full-time employment specialist that is part of a clinical team that embraces employment objectives.</p>		

What can HUD-VASH Case Managers Do to Support Veterans' Employment Goals?

While referral to VA Chapter 31, CWT or SE may be best, this is not always feasible. However, short of access to a fully-trained employment specialist, a review of supported employment principles and practices can be useful to a HUD-VASH Case Manager whose aim is to promote the employment of Veterans on their caseload. These SE principles and practices, described below,

are adapted from Swanson, Becker, Drake and Merrens (2008), *Supported Employment, A Practical Guide for Practitioners and Supervisors* (Dartmouth Psychiatric Research Center). Additional and more detailed information on supported employment can be found in the recently released Toolkit by the Substance Abuse and Mental Health Services Administration (SAMHSA), on "Supported Employment: Training Frontline Staff" http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Training_Frontline_Staff.pdf

SUPPORTED EMPLOYMENT IN PRINCIPLE AND IN PRACTICE	
PRINCIPLE	PRACTICE
Zero exclusion. Research has not been able to reliably distinguish those who will or will not succeed in employment. Anyone who has a stated wish to work is deserving of help to achieve this goal irrespective of their current clinical status or past work history.	Case Managers should embrace their clients' desire for employment and support.
Integration of vocational and treatment services. Frequent communication is needed between employment specialists and the health care treatment team in order to apply a consistent, hopeful message about work and to problem solve clinical issues that may relate to work success, such as timing of appointments, or control of psychiatric symptoms or dealing with side effects of medication when on the job.	Connect the Veteran's primary care provider (PACT team, MH caseworker, social worker) and their work program. If there is no work program available, serve as the liaison between the Veteran and the primary care provider to help with managing meds, interruptions in work due to appointments, etc. Troubleshoot. Be encouraging: a treatment team unified behind a Veteran is a huge asset, and promotes self-worth and motivation.
Competitive employment. Jobs should be obtained in the competitive economy (not sheltered work or segregated placements for people with disabilities) and pay at least minimum wage.	HUD-VASH clients are recovering from homelessness. They have faced formidable challenges and they are survivors. Don't let past difficulties limit them.
Benefits planning. Veterans and their helpers must think through and obtain reliable information on the potential impact of income on any disability benefits, many people with serious mental illness will restrict their work for fear of losing health insurance or having benefits reduced.	Candid conversations about milestones in income achievement and what they mean for benefits may be necessary. At those junctures, Case Managers should help clients determine their own goals: how do they want to live in society? What is their income potential? What might change that now or later?
Rapid job search. Job search based on Veteran preferences should begin shortly after or within a few weeks of determining the Veteran has a goal to work. Veterans can seek jobs without pre-employment training or formal assessment, or job readiness skill development. The job search should be tied to a simple vocational profile that may specify the Veteran's preferred industry sectors, the type of job skills s/he has and/or the number of hours per week desired.	Strike while the iron is hot! Use the Veteran's enthusiasm to maintain momentum. Don't wait.
Follow-along supports. Veterans with mental illness or substance abuse may need support of varying intensities for a very long time in order to succeed. In SE "cases" can remain open indefinitely.	Continue to coordinate with the PCP/MH teams, and continue to monitor your client's progress. You are in this together and for the long haul. Continue to get updates on employers and new employer contact information, encourage updates to resumes, etc.
Veteran preferences. Key tenets of SE are recovery, choice and self-determination. Client preferences are always taken into consideration and given primary value when making decisions about what jobs are sought, how many hours are worked, how SE services are provided and whether or not to disclose one's disability on the job.	Facilitate the Veteran's goals. Opening the door to stable housing may, in turn, open the doors to other life changes, but the Veteran's goals are our first priority.

Putting these seven supported employment principles into practice will require several skills. Some of these will be novel to traditional Case Managers and social workers and may require new or additional training; others will be familiar, as they are central to Case Manager practice. In general, you will be using several types of skills:

- Interpersonal, as you interview, assess, and develop a relationship with your client;
- Occupational, as you either link your clients with employment programs or help them search for, identify, and apply for jobs; and
- Managerial, as you troubleshoot, act as a liaison, and remain involved to help your client sustain employment.

Interpersonal skills: Remember that, while interviews with clients should be focused and goal-oriented, the first priority is to develop a trusting relationship. When Case Managers use open-ended questions, active listening, and paraphrasing techniques, they create an environment that is conducive to building rapport and communicating openly. Always convey respect, hope, and a positive attitude, while being careful to not give advice, convey judgment or paternalism, or argue with the client. Your approach should be individualized and strengths-based. It may be helpful to consider incorporating Motivational Interviewing techniques, as they have been shown to be highly successful in creating behavioral changes in other domains. There is some initial evidence that using these techniques can help to move Veterans past resistance to work and to a willingness to try working. Case Managers are encouraged to seek more information on MI. (<http://www.motivationalinterview.org>)

Occupational skills: Traditional supported employment specialists spend a great deal of time in the community—developing job leads, working closely with employers, visiting job sites, and being very involved with their clients on the job. While this level of intensity is not feasible for HUD-VASH Case Managers, by incorporating community employment resources, demonstrating general job search techniques, and linking the Veteran to other

services, the Case Manager and the Veteran can work together to create their own supported employment team. As you go, focus on building skills that enable the Veteran to become increasingly involved in his or her own job search:

- Help Veterans develop employment goals that are in line with their life situations. Case Managers can help Veterans identify skills, interests, or particular aptitudes for certain types of work; determine the employment setting that is most conducive to recovery and/or current abilities; and set reasonable goals for work schedules. Efforts to match the Veteran's current skills with the most suitable employment options result in better job satisfaction and tenure; for example, an outdoor job may be better suited to a Veteran who is unprepared to work in formal business setting.
- Maintain momentum. SAMHSA indicates that job finding is “where the rubber hits road” (Module 3, p4)—to maintain a Veteran's motivation to work, the job search should begin as soon as possible.
- Use community resources. Case Managers can use community resources to help Veterans identify a job lead, such as the local state department of labor career centers, the state agency for vocational rehabilitation, and community groups such as the local chamber of commerce. These groups can provide free assistance with developing a resume and learning how to interview. Job leads can also be found among personal and family contacts, previous employers, and other standard job search mechanisms such as the Internet and local advertisements.
- Work with the Veteran to determine how much help the Veteran needs. Discuss whether or not you will be working directly with the employer once a job lead has been located (often appreciated by the employer), or behind the scenes, providing guidance and support as the Veteran moves forward with the job application and interview phase. Reassess this often, as it may change as the Veteran continues to develop skills and become increasingly involved in the process.

Management skills that incorporate individualized job support: There is a tremendous accomplishment in getting a job; however the next stage of supported employment is of equal or greater importance—keeping the job. Employment specialists need to be able to provide a wide variety of follow-along job supports that are highly individualized, flexible and creative. Some job support examples include developing a successful transportation strategy; assisting with negotiating for reasonable accommodations with the employer; figuring out how to handle disclosure; managing symptoms on the job; assistance with organizing workload and keeping track of assignments; hands-on job coaching at the job; handling disagreements or problematic interactions with co-workers or supervisors; providing morning phone calls to help encourage the Veteran to get ready for work; communicating with the clinical team about needed medication adjustments; handling paychecks and budgets; and problem solving with employers.

When Case Managers do not have a full Supported Employment team to assist, there are resources that may help them tackle these problems.

HELPFUL JOB SUPPORT RESOURCES

- Job accommodation network: <http://askjan.org>
- Boston University Center for Psychiatric Rehabilitation: <http://www.bu.edu/cpr>
- Supported Employment at the Dartmouth Psychiatric Rehabilitation Center: <http://www.dartmouth.edu/~ips/>
- Benefits counseling: <http://www.ssa.gov/work/WIPA.html>

Helping Veterans with Co-Occurring Disorders

The principles of supported employment apply equally to Veterans with co-occurring substance abuse/mental health problems. However, some special considerations may be needed for these Veterans. First, the Veteran’s job profile should

include information about substance use—for example, what substances are used and how often, status of recovery and recovery stability, presence or absence of supports in their recovery from addictions, relapse triggers, etc. It will be important to choose jobs that support recovery (some jobs, for example, in drug stores or restaurants, may provide greater temptation to relapse). Communication with a treatment team can be essential to arranging for sufficient supports and interventions to prevent relapses. Ongoing supports may require special attention to prevent and attend to relapse issues. Like treating anyone with a mental illness, take setbacks in stride while continuing to take note of any accomplishments or gains. Share your belief and hope that the client can get more out of life.

Supported Education

Many Veterans, especially young adults from the OIF/OEF conflicts, will have an interest in using their GI Bill benefits to further their education. The recent “Post-9/11 GI Bill” provides increased educational tuition benefits, housing stipends, and payments for books and computers for Veterans who meet certain eligibility criteria (www.gibill.va.gov). Additionally, educational benefit programs exist for Veterans from prior wars and for those who wish to transfer their benefits to dependents or other family members. There may also be scholarships and other benefit programs available from local or state institutions, Veterans Organizations such as the American Legion, and non-profit organizations. For example, the Wounded Warrior Project offers campus support and employment services, and other reputable Veteran-centric 501c3 organizations may provide financial or other supports.

Yet while there may seem to be many possibilities, many Veterans, especially those with substance abuse and/or mental illness and/or who are recovering from homelessness, the process may seem overwhelming, especially when there are other formidable barriers to achieving these goals.

WHAT OBSTACLES OR DIFFICULTIES MIGHT CASE MANAGERS EXPECT TO ENCOUNTER AS THEY HELP CLIENTS PURSUE EDUCATIONAL GOALS?

- Difficult adjustments back to civilian life, in general, and to college life, in particular
- Lack of knowledge about benefits and how to use them, including part-time or full-time student status, out-of-pocket expenses, benefit delays, etc.
- Difficulties accessing or completing eligibility paperwork
- Differences in VA Education Benefits and Post-9/11 GI Bill
- Confusion regarding benefit itself and what it covers
- Differences in Post-9/11 GI Bill and GI Bill and education benefits for Veterans from prior conflicts
- Feelings of isolation or stigmatization on campus due to age differences, military experiences, trouble reintegrating into “normal” campus life, disabilities
- Symptom management difficulties and their effects on course demands (i.e., hearing loss due to explosions or bombs, PTSD or other mental health symptoms; difficulty concentrating due to TBI)
- Lack of knowledge or uncertainty about considering and selecting a college or program

In order to help Veterans navigate the multi-faceted pathways to benefit receipt, matriculation, and academic success, Case Managers can incorporate the principles of supported education. As a testament to its utility and potential, SAMHSA considers supported education an “emerging” evidenced-based practice for people with serious mental illness.

The seven principles of supported employment described can be applied similarly by HUD-VASH Case Managers when Veterans indicate having an interest or goal to further their education. For example, integration of education support services with clinical treatment will be important; Veteran preferences in education should always be solicited

and followed; any Veteran’s wish for education should be respected without requiring extensive educational assessments or testing. However, there are some adaptations for education settings.

In addition to the adaptations represented in the following table, there are several areas of emphasis:

- **Interface with the campus system and acquire support on campus.** Similar to working with an employer, providing supported education entails making contact with the school that the Veteran has chosen. Most supported education specialists contact and get information or assistance from staff members of administrative departments such as admissions, financial aid, or the registrar. While Case Managers may also do, or facilitate, this kind of pro-active contact with campus services, it is also valuable to attempt to set up an advocate or support person on campus. Many schools have Veterans Affairs specialists who can help navigate these procedures or answer questions; many schools have orientation sessions, and many also have Student Veterans Organizations. Additionally, there may be programs specifically aimed at non-traditional students, who also may be older, with families, etc., that may provide a welcome environment of mutual support. Medical support or special considerations should go through the school’s student disability services office, which will be able to provide information and procedural explanations when an accommodation is needed. Educational accommodations can include a note-taker in class, being allowed to tape record classes, being provided both written and verbal instructions, extended time for test taking, or access to quiet spaces or small groups for test-taking and for classes. It may become necessary to make contact with specific instructors or professors to negotiate accommodations or to problem solve if the Veteran is having trouble in a particular class.
- **Choosing an educational goal and college readiness assessment.** Some Veterans may know exactly what they want to get out of continuing their education; others have never been asked or have clearly thought about their career goals and the educational planning

ADAPTATIONS OF SUPPORTED EMPLOYMENT PRINCIPLES FOR SUPPORTING EDUCATIONAL GOALS

SUPPORTED EMPLOYMENT PRINCIPLE	SUPPORTED EMPLOYMENT ADAPTATION
<p>Zero exclusion. Research has not been able to reliably distinguish those who will or will not succeed in employment. Anyone who has a stated wish to work is deserving of help to achieve this goal irrespective of their current clinical status or past work history.</p>	<p>Any Veteran’s wish for education should be respected without requiring extensive educational assessments or tests</p>
<p>Integration of vocational and treatment services. Frequent communication is needed between employment specialists and the health care treatment team in order to apply a consistent, hopeful message about work and to problem solve clinical issues that may relate to work success, such as timing of appointments, or control of psychiatric symptoms or dealing with side effects of medication when on the job.</p>	<p>Integrate education support services with clinical treatment team, especially around medications and other symptoms that may affect work or require accommodations.</p>
<p>Competitive employment. Jobs should be obtained in the competitive economy (not sheltered work or segregated placements for people with disabilities) and pay at least minimum wage.</p>	<p>Believe in your client’s educational goals. Remember that a large part of military service is learning on the job, and that your clients’ educational base may be extensive, if informal. Acknowledge the breadth of their experiences as a way to encourage and motivate them to achieve formal academic objectives.</p>
<p>Benefits planning. Veterans and their helpers must think through and obtain reliable information on the potential impact of income on any disability benefits, many people with serious mental illness will restrict their work for fear of losing health insurance or having benefits reduced.</p>	<p>Research has shown that benefits counseling is important, but more from the aspect of helping Veterans understand their different educational benefits and by facilitating and encouraging the application for and acquisition of these benefits.</p>
<p>Rapid job search. Job search based on Veteran preferences should begin shortly after or within a few weeks of determining the Veteran has a goal to work. Veterans can seek jobs without pre-employment training or formal assessment, or job readiness skill development. The job search should be tied to a simple vocational profile that may specify the Veteran’s preferred industry sectors, the type of job skills s/he has and/or the number of hours per week desired.</p>	<p>Adapt this to follow the semester schedule or academic calendar of higher education; plan ahead, as initial planning of education goals, and the associated career objectives, can require more intense consideration than an entry-level job. Many colleges will have pre-enrollment entry assessments that can let the Veteran know whether/ which college readiness classes may be needed. A significant part of the educational goal setting will be on determining the number of classes in which the Veteran should enroll, or even whether to enroll as a part-time or full time student. Many Veterans going back to school will do best by trying a small credit load at first.</p>
<p>Follow-along supports. Veterans with mental illness or substance abuse may need support of varying intensities for a very long time in order to succeed. In SE “cases” can remain open indefinitely.</p>	<p>Like supported employment, on-going support will be needed to help the Veteran stay and succeed in school. Regular and periodic “check-ins” are needed to find out how the Veteran is doing and to be pro-active about identifying emerging problems. The need for support and advocacy will vary in intensity and may be diminished over time. Prior programs have shown that supported education services tend to be used most intensively in the first year and finish by the end of the second year of enrollment.</p>

related to achieving those goals. The Boston University model of “choosing” an education goal, or goal-setting, refers to an “*exploration of past experiences in school and work, identification of vocational interests, examination of skill and support needs in making the change, brainstorming options, research into potential occupations, and environment and decision making*” (Yim, Nicolellis and Fahey, 2002 p.76). Many colleges will have pre-enrollment entry assessments that can let the Veteran know whether and which college readiness classes may be needed. A significant part of the educational goal-setting will be determining the number of classes in which the Veteran should enroll, or even whether to enroll as a part-time or full time student. Many Veterans going back to school will do best by trying a small credit load at first.

- **Accessing GI Bill benefits.** Although the GI Bill provides many benefits, Veterans may need assistance in deciding whether to use the GI Bill or other VA supports. They may also need help with successfully applying for and receiving benefits. Often information on the GI Bill can be confusing and hard to access.
- **Ongoing education monitoring and support.** Like supported employment, on-going support will be needed to help the Veteran stay and succeed in school. Regular and periodic “check-ins” are needed to find out how the Veteran is doing and to be pro-active about identifying emerging problems. The need for support and advocacy will vary in intensity and may be diminished over time. Prior programs have shown that supported education services tend to be used most intensively in the first year and finish by the end of the second year of enrollment.

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Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your knowledge about supported employment and education.

- 1) The HUD-VASH commitment to housing stability includes facilitating the goals of supported employment and education.
- 2) If a Veteran is feeling reluctant to try to work again if he or she has been unsuccessful in the past, transitional work programs may help build confidence.
- 3) When a Veteran has difficulty interacting with co-workers or supervisors, it may be useful to get the Veteran’s permission to interact with the supervisor.
- 4) The Job Accommodations Network provides job placement services.
- 5) Transitional Work is a pre-employment program that places Veterans with employers on a temporary and permanent basis to complete work on a piece rate basis.
- 6) When considering employment options, Veterans and their Case Managers must think through and obtain reliable information on the potential impact of income on any disability benefits.
- 7) Case Managers should think through substance and abuse issues when helping a Veteran to find employment. For example, Veterans in recovery might find that some jobs in drug stores or restaurants may provide greater temptation to relapse.
- 8) Many schools have Veterans Affairs specialist who can help navigate procedures and answer questions.
- 9) A large part of military services is learning on the job. HUD-VASH Veterans’ educational base may be extensive, if informal.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) What are some resources outside of the VA that can prepare Veterans for job search and competition?
- 2) The VA offers at least four employment support programs that Case Managers can link Veterans to: VetSuccess, Compensated Work Therapy Program, Transitional Work, and Supported Employment Program. Which might be a good fit for the Veterans on your caseload?
- 3) VetSuccess, a vocational rehab program, works with Veterans on what five tracks?
- 4) A treatment team unified behind a Veteran is a huge asset. How can your HUD-VASH program integrate supported employment and education with a Veteran's other providers?
- 5) Where can HUD-VASH teams go for a list of helpful job support resources?
- 6) What obstacles might Case Managers expect to encounter as they help clients pursue educational goals?

Violence and Partner Violence Among Veterans Enrolled in HUD-VASH

What's in This Chapter?

As HUD-VASH Case Managers help families transition from homelessness, it is important to be aware of the threat of violence, particularly partner violence.

In this chapter you will learn

- How to understand and assess the risk for violence and partner violence,
- Characteristics of partner violence,
- How to address violence when children are housed with the Veteran,
- The importance of a safety plan.

After reading this chapter, you will be able to provide support to Veterans on your caseload who are either perpetrators of violence, victims of violence, or both.

Overview

Case Managers are well-placed to be the “first responders” to address family issues, broadly, and partner violence, specifically. Case Managers are skilled at providing on-the-ground services and are well-acquainted with the multiple stressors of their clients’ lives.

Family issues are critical when working with Veterans, especially those who are recovering from homelessness. Homeless Veterans consistently mention family reconciliation as one of their main concerns; Case Managers may find that up to one-half of their clients have been involved in partner violence (Institute for Women’s Policy Research, 1997).

Individuals who are at risk for homelessness, or who are homeless, may already be struggling with risk factors for violence, including a history of previous abuse, victimization, or criminal history; current substance abuse; anger management problems, and/or social isolation. Also, violence escalation is more likely when clients are experiencing other stressors, such as homelessness, worry over financial resources, lack of educational or vocational skills, and psychiatric or substance use problems—all of which may be especially relevant to HUD-VASH clients.

As HUD-VASH Case Managers help families transition from homelessness, or individuals start new chapters in their lives, it is important to be aware of the threat of violence, particularly partner violence. Partner violence occurs between two people who are or were romantically involved, and can include physical violence (such as punching and beating), sexual violence (such as rape, sodomy), and psychological violence (such as threats, stalking, and intimidation) (CDC, 2009a). Partner violence is typically mutual, with men and women being both perpetrators and victims, although males are more likely than females to inflict injury on their partners (as reviewed by Dutton & Nicholls, 2005).

Victimization by partner violence is associated with a host of negative consequences, including physical injury, psychiatric problems, and chronic health concerns. This chapter provides a brief overview of partner violence and its risk factors. Recommendations for assessing partner violence and treatment options are also reviewed.

Case Managers can provide support to clients who are either perpetrators or victims of violence (or both) in a number of ways. Case Managers can make client referrals to a psychologist and/or a family violence advocate. They can also make housing

recommendations and facilitate relations between the client and community supports (e.g. setting up a joint meeting between the Case Manager, the client, and the family advocate).

Risk Assessment with Your Clients

A number of risk factors for partner violence perpetration and victimization have been identified (CDC, 2009b); these can be assessed as part of a typical clinical intake interview. Risk factors include historical factors such as the client’s own previous abuse, victimization, and criminal history. Current factors that commonly co-occur with partner violence include substance use, trouble controlling anger, and social isolation.

It should also be noted that clients are sometimes more likely to endorse ‘mild’ forms of psychological

aggression, such as shouting, swearing, and insulting their partner, before endorsement of more severe forms of aggression, such as physical or sexual violence. Although most people engage in psychological aggression at least once in the course of a lifetime, these behaviors can escalate over time and have been shown to predict or predate physical aggression (Murphy & O’Leary, 1989). This aggression escalation is more likely when clients are experiencing other stressors, such as homelessness, low financial and educational resources, and psychiatric or substance use problems.

Endorsement of any of the risk factors reviewed below could indicate increased risk for partner violence perpetration or victimization. Although violence assessment is a critical component of each interview, it is especially crucial when a client has endorsed one or more of the risk factors.

CLINICAL INTAKE INTERVIEW RISK FACTORS ASSESSMENT		
CURRENT RISK FACTORS		HISTORICAL RISK FACTORS
Low financial resources		Victim of physical or sexual abuse
Young age		Witnessed partner violence as a child
Heavy substance use		Substance use in adolescence
Trouble controlling anger		Criminal behavior in adolescence
Belief in strict gender roles (on individual or cultural level)		History of aggression (e.g. reports getting into physical fights with peers or partners)
High relationship conflict (multiple separations and reunifications, report many conflicts and fights)		NOTES:
One partner is economically dependent on the other		
Social isolation		
Easy access to alcohol, drugs, and/or firearms		

When Dependent Children are Housed with the Veteran...

In addition to the negative consequences of partner violence for the victim, the impact of partner violence on children cannot be overstated. Violent homes are more likely to include children than non-violent homes (Rennison & Welchans, 2002), and the majority of violent incidents in family homes are witnessed by children (Hutchinson & Hirschel, 2001). Witnessing partner violence is associated with both internalizing and externalizing problems in childhood, as well as academic and health problems for the child (Graham-Bermann, & Seng, 2005; Kernic et al., 2002). Further, children in homes with partner violence are more likely to be abused (Edelson, 1999). A child abuse assessment should be completed when Case Managers suspect that partner violence is occurring. After the family is housed, Case Managers will support the family through this understandably stressful transition. During this time period, Case Managers can inquire about child adjustment, typical parenting discipline strategies, and how the couple is getting along in an effort to learn more about how the family is adjusting to their new home and how they are dealing with conflicts as they arise.

Assessments

It is important to note that assessment success is not the disclosure of partner violence. Rather, success is the development of a relationship that is compassionate and trusting. Partner violence perpetrators and victims may be understandably reluctant to discuss their relationship difficulties with a relative stranger. Indeed, it is difficult for any of us to admit that we are having trouble and need help. With compassionate and neutral questions that demonstrate caring and interest in the client, the Case Manager can facilitate a relationship that increases the likelihood of disclosure over time.

- **Know the laws:** Before assessing family violence, a Case Manager should be up-to-date on state reporting laws and should privately review rules of confidentiality with the client, explaining what must be reported, when, etc., especially if there are children involved.

- **Demonstrate willingness to address the issue:** Case Managers can demonstrate that they are aware of family violence and that they are supportive of victimization and perpetration disclosure, including displaying posters that address violence and providing freely-available literature on violence that demonstrates receptiveness (Bacchus et al, 2003).
- **Provide privacy:** Disclosure is also more likely during individual conversations with the client in a private room (Thackeray et al, 2007).
- **Be attentive, compassionate, and concerned:** Clients are more likely to feel comfortable disclosing when providers are attentive, compassionate, and concerned (Bacchus et al, 2003). Of course, all Case Managers aim to demonstrate these qualities, but it can be difficult given large caseloads and limited time for the violence assessment.

A partner violence assessment can be brief, with time allowed for further discussion, and should include a few key components. It is recommended that Case Managers develop a list of local referrals for domestic abuse shelters, anger management training, and professionals specializing in violence victimization and perpetration before beginning a partner violence assessment.

Although there is conflicting evidence on whether women are at increased risk for partner violence during pregnancy, victimization during pregnancy is associated with a host of serious consequences for both the woman and the fetus (Jasinski, 2004). The partner violence assessment for victimization recommended by the American Congress of Obstetricians and Gynecologists includes many of the components described above. They suggest the following script: *“Because violence is so common in many women’s lives and because there is help available for women being abused, I now ask every patient about domestic violence: 1) Within the past year, or since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone? 2) Are you in a relationship with a person who threatens or physically hurts you? 3) Has anyone forced you to have sexual activities that made you feel uncomfortable?”*

When partner violence victimization or fear of the partner is disclosed, a safety plan should be developed with the client. Safety plans are best discussed and prepared between the client and a trained family violence advocate. Safety plans are discussed here in brief to provide an overview of the important issues that should be discussed. When clients are entering a new housing situation, a safety plan can help them feel safe and more equipped to address the risk for violent conflict in a new location.

VIOLENCE ASSESSMENT STRATEGIES

1. Begin with normalizing statements that frame why you are asking about violence.
2. Ask open-ended questions about situations that may result in partner violence.
3. Ask about specific behaviors. The CDC offers a full compendium of partner violence assessment measures, titled *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools*, at no cost on their website (http://www.cdc.gov/ncipc/dvp/Compendium/Measuring_IPV_Victimization_and_Perpetration.htm). This compendium includes various measures that list specific behaviors and can be used to assess violence.
4. If partner violence victimization is disclosed, the Case Manager should make appropriate referrals to local shelters, psychologists, and primary care physicians. Law enforcement involvement should also be discussed with the client. Calling the National Domestic Violence Hotline at 800-799-SAFE with the client can be an important first step to identifying local resources for the client.
5. If partner violence perpetration is disclosed, referrals to psychologists, psychiatrists, and couples therapists specializing in partner violence are recommended. Local domestic violence shelters may lead groups for abusers as well.
6. Assess for child abuse if appropriate.

WHY A SAFETY PLAN?

1. Safety plans can help clients develop safety strategies that can be used during a potentially violent incident.
2. Safety plans can help develop a course of action if a client decides to leave the relationship or the house.
3. More elaborate safety plans may include an identification of ways to stay safe both within the client's home and in public.
4. Safety plans may address the increased risk of violence while using drugs or alcohol and prompt the client to anticipate these risks before engaging in substance use.
5. A less immediate, but equally important way of improving clients' safety can include helping clients improve their ability to make their own income, through job training or education, which in turn may reduce their risk of violence victimization in the future (Farmer & Tiefenthaler, 1997).

Interventions

Two common and effective interventions that Case Managers may consider with clients who have both housing and violence-related problems are reviewed below. Behavioral Couples Therapy is a treatment originally designed to address alcoholism, but has been shown to improve relationship functioning (O'Farrell & Fals-Stewart, 2006). Anger Management is an intervention designed to prevent and decrease anger and interpersonal violence (Reilly & Shopshire, 2002; Reilly et al, 2002).

Behavioral Couples Therapy (BCT)

BCT was created based on two fundamental beliefs: that a non-drinking partner can reward abstinence, and that risk of relapse is lower when relationship quality is increased. BCT is typically 12 sessions long and addresses both the alcohol and relationship issues. First, drinking-focused sessions include

- a daily "trust discussion" in which the patient states that he or she will stay abstinent that day and the partner expresses support for the patient's effort,

- a Recovery Contract with a calendar to record 12-step meetings attended,
- helping the non-drinking partner to identify behaviors that may trigger or enable the client's excessive drinking and decrease those behaviors, and
- helping the couple decrease the patient's exposure to alcohol.

Second, relationship-focused sessions address issues related to increasing positive feelings between the couple and engaging in activities together. Communication training is also an important activity aimed at supporting the relationship.

Anger Management for Substance Abuse and Mental Health Clients

Anger Management for Substance Abuse and Mental Health Clients is a manualized treatment developed by Dr. Patrick Reilly and colleagues. The manual and the accompanying participant workbook are published by SAMHSA and freely available on the web at <http://kap.samhsa.gov/products/manuals/pdfs/anger2.pdf>. The purpose of the intervention is to help a patient learn to manage anger effectively, to stop violence or the threat of violence, and to teach a patient to manage anger without resorting to violence and adopt alternatives to violence. The "active ingredients" of this intervention are learning to recognize internal and external anger cues, use of time-outs, relaxation training (counterconditioning), cognitive restructuring, communication skills, and development and use of a personal violence-prevention plan.

In studies at the San Francisco Veterans Affairs Medical Center, using a 12-week form of the intervention with substance use disorder patients, anger, violence, and substance use were significantly reduced between the beginning and the end of treatment, and these improvements were maintained 3 months later. Decreased levels of anger and violence were also associated with abstinence. The intervention was effective with patients who had been abusing a variety of substances; with patients having a co-occurring psychiatric disorder, and those who were taking psychiatric medications; with both men and women; and with patients from

different age and racial/ethnic groups. Patients were satisfied with the intervention and attendance at sessions was good.

Working with Family Members

Family involvement in Veteran mental health services is a national priority (VHA Directive 2006-041). In 2003, the President's New Freedom Commission called for family-centered service and treatments. This spotlight on the importance of family involvement was championed in the VA Secretary's New Mental Health Strategic Plan (2004). Specifically, this plan called for "Veteran and family care that is recovery-oriented, high quality, and maximizes the delivery of evidence based practices." The Office of Mental Health Services' VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, reiterated this commitment to incorporating families, stating that the Veteran's principal mental health provider should incorporate family into coordination and development of the treatment plan, and, when appropriate and with the Veteran's consent, should maintain communication with the family regarding the treatment plan. Understandably, many providers do not have previous experience working with families. Given the significant clinical skill that Case Managers bring to the job, incorporation of family members can be eased with the following suggestions.

- Family relationships can be conflictual and change with time. Veterans may not be interested in contacting family when they enter services, but may feel differently as treatment and housing progress. Given significant evidence that family involvement in treatment is associated with improved treatment outcomes in a variety of psychological disorders, Case Managers are encouraged to discuss potential family involvement throughout treatment.
- When Veterans begin treatment, they may be unsure about how to reconcile with their families. Providers can ease this process by slowly incorporating the family into the treatment.

- Releases of information do not need to mean that the Veteran allows family members access to all information. Releases of information can be one-way (the provider will listen to the family members but not disclose any information) or limited (e.g., providers will talk about housing and family meetings with family members but will not discuss a Veteran's substance use).
- Veterans may have children who are still minors, and thus may face child care and child support issues. Further, Veterans may have conflicted feelings about reuniting with their children—on one hand, hoping to be a part of the child's life, and, on the other, concern about whether they will be able to provide for the child in the way they would like to. Providers are encouraged to discuss and validate these concerns with the Veteran. Noting that reconciliation can be a slow, rewarding, and difficult process will help prepare a Veteran for the inevitable bumps in the road.

For more information on working with newly returning Veterans and their families, please see Makin-Byrd, Gifford, McCutcheon, & Glynn (in press).

In summary, partner violence is a crime of concern among homeless Veterans and others served at HUD-VASH. Not only is partner violence associated with negative consequences for the victim, but partner violence is harmful to children who observe it in the home as well. Various proximal and historical risk factors are associated with partner violence and can serve as clues to the risk of violence perpetration and victimization among clients. Case Managers are in a unique and important position to both assess violence with their clients and impact their clients' safety through multiple mechanisms, including referrals for education, housing, psychological help, and family violence advocacy.

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Test Your Knowledge!

Quick Check: Answer "true or false" to the following statements to check your knowledge about violence and partner violence among Veterans.

- 1) Case Managers may find that up to one-half of their clients have been involved in partner violence.
- 2) Risk factors for partner violence perpetration and victimization should be determined in a separate assessment process following program intake.

- 3) Individuals who endorse "mild" forms of psychological aggression such as shouting, swearing, and insulting their partner are not likely to endorse more severe forms of aggression such as physical and sexual violence.
- 4) Assessment success is not the disclosure of partner violence; it is the development of a relationship that is compassionate and trusting.
- 5) Case Managers should not discuss family violence with Veterans unless they suspect that it is occurring.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) What are some common risk factors for violence?
- 2) What are some things a Case Manager can inquire about to determine how children are doing after a family is housed?
- 3) It is recommended that HUD-VASH teams develop a list of local referrals for domestic violence shelters, anger management training, and professionals specializing in violence. When should this be done and what resources exist in your community?
- 4) What are some of the reasons to develop a safety plan?
- 5) Two common and effective interventions that Case Managers may consider with clients who have both housing and violence-related problems are behavioral Couples Therapy and Anger Management for Substance Abuse and Mental Health Clients. What techniques do each of these interventions promote that your team can use?
- 6) Many providers do not have previous experience working with families. What are some ways that family members can be incorporated into case management?

Peer Support in HUD-VASH

What's in This Chapter?

Peer Support Specialists (PSS) and Peer Support Technicians (PST), used here interchangeably, are paraprofessionals who publicly self-identify as having a mental illness and/or are in recovery from substance dependency. This chapter is intended for those who serve on a HUD-VASH team as a Peer Support Specialist and those who will be working alongside and supervising PSSs.

In this chapter you will become familiar with

- How to hire, train, and supervise a PSS,
- The differences and similarities between the work of the PSS and the Case Manager,
- Peer group topics, and
- Examples of peer support in action.

After reading this chapter, you will know the benefits of peer support and how to incorporate a Peer Support Specialist into your HUD-VASH team.

Introduction

Of all the resources available to help the HUD-VASH Treatment Team further the recovery goals of Veterans recovering from homelessness, one of the most important may be the Peer Support Specialist.

The Department of Veterans Affairs (VA) is currently implementing recommendations from the President's New Freedom Commission for the care of people with serious mental illness (DHHS, 2003). The Commission's 2003 report concluded that recovery-oriented systems that focus on high-quality services and evidence-based practices improve both the accessibility and quality of health care. To operationalize the Commission's report, VA created

an action agenda (DVA, 2003) and a Mental Health Strategic Plan (VHA, 2004). The Strategic Plan calls for use of peer support within VA and includes a specific recommendation to hire Veterans as Peer/Mental Health para-professionals.

Known within VA as Peer Support Specialists (PSSs) or Peer Support Technicians (PSTs), these paraprofessionals, in contrast with traditional staff, are publicly identified as being in active recovery from mental illness. Like addiction treatment counselors who themselves have experienced addiction, PSSs draw upon their lived experiences to share "been there, done that" empathy, insights, and skills. They serve as role models, inculcate hope, engage patients in treatment, and help patients access supportive programs, supportive social networks and other peers, and community resources (Chinman et al., 2006; Simpson & House, 2002; Solomon, 2004). A review of PSS research (Chinman et al., 2006; Davidson, Chinman et al., 1999) shows that PSTs can reduce inpatient utilization, substance use, social isolation, and symptoms by modeling community living, enhancing social networks, and improving Veterans' treatment adherence and participation. Additional studies have shown that PSTs can be deployed with no detrimental effects, yielding clinical outcomes equivalent to non-PST staff.

In 2007, in a letter to State Medicaid Directors, the Centers for Medicare & Medicaid Services (CMS) stated that peer support—specifically, the type of peer support that is provided by a PSS—is an "evidence-based mental health model of care".¹²

¹² <http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html>

In 2005, VA began funding PSS positions across its national health care system. By August 2007, a total of 91 had been hired. That number increased to 123 by April 2008 and to 237 by April of 2010. While the PSSs work in many different areas—MHICM, PR RTPs, general mental health clinics—HUD-VASH leadership is now recommending that they be deployed within HUD-VASH teams.

This chapter is intended for those who may be soon serving on HUD-VASH teams as Peer Support Specialists (PSS) and those who would be working alongside and supervising PSSs. This chapter provides information about what a PSS role could be in HUD-VASH and how the PSS could work with the HUD-VASH Case Manager. This chapter also highlights how the PSS could serve as a role model and as a source of encouragement and support to Veterans receiving HUD-VASH services.

Case examples are included to illustrate how PSSs could facilitate discussions on topics of particular concern to HUD-VASH Veterans, or how the PSS continues to meet with Veterans regularly even once they have fully integrated into the community in which they live. It also includes special considerations that are unique to the role of the PSS.

Overview of Potential Peer Support Specialist's Responsibilities

During the often lengthy and difficult process of rebuilding a life in the community, Veterans receiving HUD-VASH services can benefit greatly from the support of someone with similar experiences—someone who can offer advice and empathy when the Veteran faces challenges along the way. In addition to being a Veteran themselves, each PSS deployed within HUD-VASH will likely have recovered from challenges (homelessness, unemployment, substance abuse, and mental illness) similar to those faced by the Veterans with whom they are working. Each will also have received training specific to serving as a PSS. PSSs advocate for the Veterans on their caseload, share wellness and relapse prevention strategies, and provide practical supports to improve socialization and community life skills. The unique mix of camaraderie and leadership empowers Veterans to self-determine

their own recovery goals. PSSs would be full staff members on the HUD-VASH team; as such, their role would be as central no matter what stage a Veteran is in within HUD-VASH services. For example, PSSs can facilitate weekly peer support group sessions prior to a Veteran receiving a voucher. In that case, these sessions could present opportunities for rapport-building, discussions of the upcoming transition, and assessments of anticipated practical supports, while introducing and emphasizing self-care and socialization skills. PSSs who have not facilitated groups before should look to the HUD-VASH Case Manager (CM) or Clinical Supervisor as models, or they may request training to help them develop confidence and skills as a group leader.

If service delivery is initiated after the Veteran has transitioned to the community with their voucher, the PSS could address the same topics as they become relevant to the Veteran in one-to-one conversations. Peers meet with the Veteran, often in the Veteran's new place of residence, ensuring that the Veteran is utilizing the appropriate supports (including community mental health and substance abuse treatment programs, 12-step meetings, and vocational/educational rehabilitation services). If the Veteran is not using these supports, PSSs can facilitate the process by accompanying Veterans to 12-step meetings or by assertively bringing them to their appointments. In their "check in" sessions with Veterans, PSSs can reinforce the work Veterans have done with any other treatment providers they may have.

Implications of the "Critical Time Intervention" Model

HUD-VASH teams are increasingly being asked to use the tested model of "Critical Time Intervention" (CTI) case management. This approach offers different types of support to the Veteran in different phases of the transition to community life. The three distinct phases of care are (1) Transition to community (the initial phase of intense support), (2) Try-Out (in which the Veteran accepts increasing responsibility for maintaining a healthy approach to life), and (3) Transfer of care (in which the Veteran relies increasingly on community supports rather than the

HUD-VASH team, and the case management part of HUD-VASH program comes to an end). Consistent with the CTI approach, the team gradually reduces its frequency of contact with the Veteran over the course of the intervention to reinforce the use of community supports and independent living. Therefore, peer support must be provided in a way that fosters independence and focuses on helping the Veteran learn self-advocacy skills and establish

connections in the community that he/she can maintain independently (see Table 1 below for details). In order to accomplish this, the PSSs ought to work in close collaboration with the HUD-VASH CM. Both the PSS and CM have the mutual goal of ensuring that Veterans assigned to their team have the resources and skills they need to achieve the goals they have set for themselves as well as for continued growth in their recovery.

OVERVIEW OF THE PEER SUPPORT SPECIALIST'S RESPONSIBILITIES, BY CTI PHASE		
In the <i>Transition to Community</i> Phase, the PSS:	In the <i>Try-Out</i> Phase, the PSS:	In the <i>Transfer of Care</i> Phase, the PSS:
<ul style="list-style-type: none"> • Meets with the Veteran periodically to establish rapport and encourage the Veteran in the changes he or she is making • Provides input on the HUD-VASH Housing Stabilization plan • Conducts group or individual peer support sessions on topics related to the transition to healthy living in a community setting • Works with the HUD-VASH CM to identify community resources essential for successful community integration • If a Veteran is being discharged with the case management portion of HUD-VASH, PSSs can assist with executing a discharge plan and help the Veteran overcome barriers that arise in using key community supports, including accompanying the Veteran to appointments and meetings when helpful 	<ul style="list-style-type: none"> • Continues to facilitate linkages that have already been established, helping the Veteran think through and resolve obstacles and challenges • Identifies any gaps in support system, barriers in accessing services, or areas where the Veteran needs more support, and works with the CM and other providers to address these gaps 	<ul style="list-style-type: none"> • Celebrates the Veteran's ability to maintain goals in healthy living and puts relapses or slips in perspective • Reflects (with the Veteran) on work that has been accomplished thus far and acknowledges the reduction or end of participation in case management portion of the HUD-VASH program • Reminds Veteran of supports that have been established, says goodbye, and wishes the Veteran the best of luck in continued recovery

Working Effectively in a HUD-VASH Treatment Team

The number of PSSs who are hired on any one HUD-VASH team may ultimately impact how PSSs are used. Although the numbers of PSSs to be hired is not known now, one possibility is that each HUD-VASH team could hire a small number of PSSs (1-3). Therefore, one option is to replicate what has been

done with other case management teams in VA (e.g., MHICM) and have the PSSs be “floaters” who work with many Veterans as an additional support to Case Managers. In this scenario, there are some different ways it could be decided that a particular PSS works with a particular Veteran. For example, the PSSs, along with Case Managers, could be the ones to decide which Veterans would benefit from the additional support. PSSs are often called upon when

Case Managers are having a difficult time engaging a Veteran, specifically because the PSSs and the Veterans “speak the same language.” Alternatively, Veterans may seek out a particular PSS as a result of a chance meeting or upon a referral from another Veteran in the HUD-VASH program. Such initiation of contact is acceptable, but the PSS and Case Manager should still discuss the issue first before confirming that it is an acceptable assignment for the PSS. Regardless of how the contact between Veterans and PSSs is initiated, when a PSS discusses issues of clinical significance (i.e., issues that relate to the Veteran’s mental health or substance abuse recovery) with Veterans who are assigned to a HUD-VASH Case Manager, the PSS must encourage each Veteran to relay any relevant information to the Case Manager to whom that Veteran is assigned, as this is often information critical to recovery.

After it is decided that a Veteran will work with a PSS, for the PSSs to work effectively with HUD-VASH Case Managers, it is critical that they both share information with one another about the contact they have with the Veteran they share. These communications help team members support each other’s work and track evolving issues that may require special intervention. The PSS may tell the CM that the Veteran has been seeing drug-using friends at their old haunts, or a CM may tell the PSS that a Veteran has been shy and nervous about going to AA meetings and asks the PSS to offer to attend a meeting with that Veteran. At supervision meetings with a Clinical Supervisor, or earlier if necessary, the PSS/CM pair should share any serious problems on which they would like guidance or assistance,

preferably at an early enough stage to plan an intervention.

Veterans are informed at the outset of their participation that information is shared among HUD-VASH team members to better facilitate their care. Therefore, depending on the issues to be addressed and the preferences of each Veteran, PSSs and CMs may meet with the Veteran together or separately. When the PSS and CM meet with the Veteran separately, the authors suggest that the PSS and CM meet and discuss their observations and concerns regarding the Veteran. By working together smoothly, PSSs and CMs can enhance their effectiveness and ensure each Veteran enrolled in HUD-VASH is receiving consistent messages and support. Within individual pairings of PSSs and CMs, many roles and responsibilities are shared, with each person offering his or her skills and perspectives to assist the Veteran in achieving important goals. Each person, however, also has areas of primary responsibility (see the Table 2, “Responsibilities/ Roles of the HUD-VASH Peer Support Specialist and Case Manager”). For instance, the HUD-VASH CM takes the lead in the developing the Housing Stabilization plan, but the plan should reflect the PSS’s input. While CMs ensure that the appropriate 12-step supports are in place, it is the PSS who actually accompanies Veterans to meetings if necessary. When one staff person assumes a primary role in a certain area, the other provides assistance and can serve as a backup when that staff person is temporarily unable to fulfill that duty (for example, due to absence or sickness).

RESPONSIBILITIES/ ROLES OF THE HUD-VASH PEER SUPPORT SPECIALIST AND CASE MANAGER

Primary Responsibility of PSS, with Input from the CM	Primary Responsibility of CM, with Input from the PSS	Responsibilities Shared by the CM and PSS
<ul style="list-style-type: none"> • Share with Veterans their story of how they overcame homelessness to promote hope • Help Veterans advocate for themselves with providers and ensure effective two-way communications • Recreational planning and modeling healthy living using free or low-cost community resources • Linkage to community mental health and substance abuse recovery programs (NA/AA) • Accompany Veterans to clinical appointments, job interviews, recreational activities, and self-help group meetings • Increase motivation toward recovery goals 	<ul style="list-style-type: none"> • Develop Housing Stabilization Plan • Conduct the Comprehensive Housing Assessment • Orientation/introduction to HUD-VASH, transition to community, and discharge plans • Management of process to secure voucher • Management of clinical crises • Identify, monitor, and provide referrals for trauma-related symptoms • Provide vocational/educational supports as needed: interview skills training, resume building, linkages to education and training programs • Facilitate linkage to other clinical services • Communicate with clinical service providers • Review and work through benefits and entitlements issues (Social Security Income and Social Security Disability) 	<ul style="list-style-type: none"> • Weekly team meetings of HUD-VASH staff • Linkage to needed community services, including vocational/educational supports and trauma-related treatment resources • Assistance with finding and maintaining housing • Communication with landlords • Ongoing monitoring of symptoms, psychoeducation and training in symptom management, coping skills, medication compliance, problem solving, and relapse prevention • Transportation assistance • Provide support during job stresses • Provide support during clinical crises • Refer out as appropriate during exacerbation of symptoms

Role of the Peer Support Specialist

Orientation to the HUD-VASH Program

Once the Veteran has been determined eligible and has expressed interest in the HUD-VASH program, it would be extremely helpful if a PSS was involved, along with a CM, in introducing the Veteran to details of HUD-VASH and conducting the Comprehensive Housing Assessment. The assessment is an important first step in HUD-VASH as it is an opportunity for the HUD-VASH team to learn about the Veteran's goals, barriers, strengths, hopes, and interests as well as the Veteran's triggers, coping skills, and available supports; establishing the foundation for a healthy working relationship between the Veteran and HUD-VASH staff; building the Veteran's understanding of the program and

what to expect; encouraging hope by letting the Veteran know that he or she will have both support in meeting obstacles that may arise – as well as people who will cheer and celebrate as goals are met. The PSS can have a key role in the assessment process by being an effective bridge, helping to explain the details of HUD-VASH to the Veteran and clarifying for the Case Manager the preferences of the Veteran.

During these initial meetings, the PSS must explain the PSS's role, as many Veterans may not be familiar with the PSS position. The PSS and the CM together should explain how the PSS's role is different than the CM's and offer to help clarify any aspects of the PSS's role that the Veteran might not understand. In general, Veterans appear to be relatively comfortable with the informal nature of the relationship with

the PSS. Sometimes, however, establishing rapport with a Veteran enrolled in the HUD-VASH program will take some extra work. Also, in past deployments of PSSs, some Veterans have expressed hesitancy in working with the PSSs. While this has been a minority of situations, Veterans should be allowed to decline involvement with PSSs if they so choose.

Providing Input into the Housing Stabilization Plan

While HUD-VASH staff will likely have administrative responsibility to create the Housing Stabilization Plan for each Veteran entering HUD-VASH, it will be helpful for PSSs to have input into this plan. The PSS's input is coordinated through the CM assigned to the Veteran. This input reflects insights gained from informal contacts, observing the Veteran's behavior in group sessions, and from information learned from regular team meetings. The PSS can offer personal insights and observations about the Veteran and his or her needs. For example, the PSS might feel that a particular apartment might or might not be a good fit for a particular Veteran (e.g., proximity to former drug using friends) and could share this recommendation and the reasoning behind it. The Veteran and the HUD-VASH CM should take these insights into account as they finalize the plan. When conflicts arise between the PSS and CM regarding the care of a Veteran enrolled in HUD-VASH, the issue should be raised with the Clinical Supervisor, who works with each party to provide guidance and resolve the conflict. One important component of the Housing Stabilization Plan is that both CMs and Veterans are supposed to commit to certain tasks in support of each of the goals specified in the plan. PSSs should also be included and could commit to various tasks as well.

Conducting Peer Support Groups for the Early Stages of HUD-VASH

One role that PSSs can play very well is to lead groups for Veterans. There are many different types of groups that PSSs could run, including unstructured peer support groups, Vet-to-Vet groups, or NA/AA groups. However, one particular group format that is a good fit for Veterans

entering into HUD-VASH is the peer support groups associated with the MISSION-VET program. MISSION-Vet is a tested program specifically developed to target the mental health, substance abuse and related issues facing homeless Veterans through assertive outreach, psycho-education and linkages to community-based resources, and peer support. The group sessions were designed to be held by the PSS weekly for approximately 60-90 minutes. The 11 topics (see *Peer-led Sessions* table) have been identified by PSSs from past MISSION projects as having particular relevance to those Veterans preparing for independent community living.

These group discussions can serve several purposes. The first is to provide an opportunity for Veterans to socialize with other Veterans who are facing many of the same issues. A key challenge for homeless Veterans with possible mental illness and drug and alcohol problems is social isolation. In particular, Veterans who have drug and alcohol history may need to start building a completely new social network of persons who do not use substances. Second, the weekly peer-led sessions offer Veterans a forum to air their concerns, fears, questions, and hopes in a safe environment, knowing that they will not be judged and knowing that their peers (both the HUD-VASH PSS and their fellow Veterans) will support them. These sessions also offer a chance to begin work on developing some of the skills and achieving some of the goals specified in the Housing Stabilization Plan. This group would probably be most helpful for Veterans who are early on in the HUD-VASH program, either while they are going through the voucher process, while they are looking for housing after the voucher was issued, or even soon after the Veteran was housed. Alternatively, these same sessions, using the same 11 topic areas, could be delivered in a one-on-one meeting between a newly housed Veteran and a PSS at the Veteran's residence. These peer-led sessions would similarly allow the Veteran to air any concerns with living arrangements or adjustment to the community, ask additional questions, and express their future hopes in a comfortable, relaxed environment free of judgment and full of support. The PSS could then identify problems and relay information back to the team.

Peer Support Session Topics From MISSION-VET

1. Willingness	7. Significance of honesty
2. Self-acceptance and respect	8. Courage
3. Gratitude	9. Patience
4. Humility	10. Medicine maintenance
5. Dealing with frustration	11. Making a good thing last
6. Handling painful situations	

Providing Ongoing Support in the Community

PSSs often offer individual support to the Veteran in areas that overlap with the support provided by the HUD-VASH CM. This includes offering support in getting and maintaining safe housing, sustaining recovery from substance abuse, managing mental health symptoms, obtaining gainful employment, and achieving educational goals. The type of support that PSSs offer can be practical and/or emotional; for example, they might offer to accompany Veterans to initial mental health appointments, bring them to AA or NA meetings, tell them what to expect in their pursuit of housing, or offer advice and support as Veterans try to reconnect with their families. Below are descriptions of specific experience-based competencies that PSSs have, and real case examples of how PSSs applied those competencies.

- **Reducing Fear** - Achieving life goals requires overcoming fear of failure and fear of the unknown. Having been homeless and through institutional treatment, Veterans might doubt their ability to succeed on their own, to remain sober, and to adjust to work and other aspects of community life with which they have become unfamiliar. Veterans might also fear taking medications or being stigmatized in the community as a result of their conditions or treatment. Having been through similar experiences, PSSs are able to provide emotional support and practical advice for facing these challenges. A Veteran might call because he or she had a “drug dream,” had a fight with a spouse or partner, or is simply feeling the urge to use drugs.

Peer Support in Action: Example 1

“Isaac” was so debilitated by his co-occurring mental illness, drug addiction, and alcoholism that he could not by himself take the necessary steps to secure housing, even though he had already secured a voucher through HUD-VASH. Now, Isaac faced the possibility of having his voucher removed after he relapsed, and in a panic he called the PSS for help. By facilitating access to resources, the PSS was able to find Isaac a secure house located close to the VA hospital, where the HUD-VASH team could monitor and support him during this critical time. With this new housing placement arranged by his PSS, he was able to easily acquire his medications, get mental health counseling and treatment, and take care of other VA-related business. Throughout this process, his PSS provided encouragement, support, reassurance, and positive feedback to help Isaac overcome his paralyzing fear and to take the necessary steps back to a positive lifestyle.

- **Accompanying Veterans.** Another way in which PSSs can provide practical support to Veterans is to accompany them to their first appointments, as they learn unfamiliar public transportation systems, or when they need to buy groceries or shop for clothes. The PSS continues to accompany Veterans on these activities until they are comfortable doing such tasks on their own. For example, a PSS who has shopped for a child before might accompany a Veteran who is trying to reunite with his family to help him buy clothes for his children. This support can be especially critical in times when the Veteran stumbles on his or her recovery path. The PSS can provide moral support if the Veteran experiences psychiatric symptoms requiring hospitalization, or by accompanying him/her to a detoxification facility if he or she begins using again.
- **Promoting a healthy lifestyle.** A healthy lifestyle includes eating well, getting enough sleep, and exercising regularly. Sleep, exercise, and nutrition can all play a positive role in relieving stress and improving mood, while smoking and caffeine might have negative impacts. While recognizing that “old habits die hard,” the PSS can help to promote healthy lifestyles with new habits of self-care.

Peer Support in Action: Example 2

“Ricardo” had recently secured housing in the community through HUD-VASH. However, one month after he had gotten his own housing, he relapsed and was in danger of becoming homeless again because he had stopped paying his portion of the rent. Ricardo was spending a great deal of time on the street, stopped eating and bathing, and could not hold down a job. His PSS arranged a face-to-face meeting with him and talked to him about his weight loss, disheveled appearance, and inattention to personal hygiene. His PSS asked him directly, “What do you need to get back on the road to recovery?” This meeting with his PSS helped Ricardo realize that before he could make more progress, he needed to understand the reasons that he fell off his path to recovery in the first place. Ricardo acknowledged that he had gotten comfortable with his present condition and stopped putting in the necessary work to maintain his recovery. Once Ricardo determined to pursue a healthy way of life, his PSS helped link him to a detoxification program. His PSS also helped educate him about the importance of hydration, selecting healthy foods, avoiding unhealthy foods, monitoring caloric intake, and exercising. With ongoing peer support, Ricardo began reclaiming his recovery by attending programs, taking classes, and seeing his family.

- **Socializing.** For Veterans who are transitioning back into the community, having drug-free social events in which to participate and friends with whom to spend time can have a positive impact upon recovery. Eventually, HUD-VASH case management will be scaled back; therefore, developing positive and drug-free social relationships can become an important source of support after that part of the program ends. In general, PSSs can share ways that worked for them as they were developing new friends in the community. This could involve taking classes, volunteering, joining clubs, or participating in religious institutions. What is important is that the PSSs learn what the Veteran is interested in and then help him or her participate, even accompanying the Veteran the first few times. If applicable, one avenue for socialization upon which the PSS can rely is AA and NA social events, because these

events tend to be larger and better established, offering Veterans recovering from substance abuse in the program certainty that the event will be well-attended and thus worth their time. Such 12-step events might include dances or other enjoyable activities. At times, PSSs may also set up small, informal social events for Veterans on their caseload. For example, a PSS might get together with three or four Veterans to eat pizza and play pool, each chipping in if another Veteran who attends does not have enough money to participate. Especially as Veterans return to work, social events are more likely to be successful on evening or weekend hours. Ideally, the work schedules of PSSs will include some evenings and weekends. Indeed, one of the hallmarks of peer support is that it is generally available when more traditional services are limited and when Veterans are most in need of natural support and opportunities for social connectedness. Although PSSs have a working schedule that mostly follows “normal business hours,” employing a mechanism that allows them to use “comp time” to shift their working hours, when necessary, is useful. However, PSSs also tend to have natural contact with Veterans during nights and weekends since they often participate in the same type of activities as a part of their own personal lives (for example, going to AA or NA meetings/activities, church, and grocery shopping).

- **Achieving goals.** As someone who has had experiences similar to those of the Veterans enrolled in the HUD-VASH program, the PSS often has excellent insight into what can be considered realistic goals for Veterans to set and achieve. Veterans who are really struggling might have goals that seem trivial to an outsider, but which are understood by those who have experienced similar struggles. For example, a person who is feeling extremely depressed might have as a goal to smile three times per day or to go out in public twice a week and talk to someone. Of course, PSSs should help set goals as high as the Veteran wishes, with shorter-term objectives being developed in the interim. Most likely, the goals will center around the pursuit and maintenance of housing

as specified in the Housing Stabilization Plan. After goals are set, it is important for the PSS to regularly check in on the status of those goals in order to ensure progress.

Peer Support in Action: Example 3

“Earl” faced a financial barrier to consistently paying his portion of his rent. He had accumulated many fines over the years and could not pay them on the salary he earned at his current job. His assigned PSS had also experienced a struggle with outstanding fines and explained to Earl how he had set paying off his fines as a goal and decided to quit smoking as a way of saving money to pay off those fines so he could get his license back. Using the eight dollars a day he had spent on cigarettes, the PSS was able to slowly pay off his fines and more consistently pay his portion of his rent. Even now that he has paid off his fines, he has decided to no longer smoke cigarettes. The PSS’s sharing of his personal experiences showed Earl that the barrier he faced was not an insurmountable problem, helped motivate Earl to seek a better paying job with the VA, and also modeled healthy behavior (smoking cessation). Through perseverance, Earl got that VA job and was finally able to pay off his fines.

- **Working.** As someone undertakes the responsibilities of a full-time job after experiences similar to those of the Veterans currently enrolled in the HUD-VASH program, the PSS is a natural role model for providing support to a Veteran who is considering returning to work, trying to find the right job, or adjusting to working life. Many Veterans in the HUD-VASH program have extensive criminal records and limited work experience; therefore, they often have difficulty finding a job or have to start out working in less desirable positions. The role of the PSS is to reinforce the work that the staff from the HUD-VASH team does in preparing Veterans for work—teaching them how to address questions that interviewers might have about their pasts, stressing the need for punctuality and showing up for work every day, or helping them cope with unpleasant work experiences.

Peer Support in Action: Example 4

Marcus lost a well-paying job with the VA when he relapsed to cocaine use. He asked for support from his PSS, who understood first-hand the impact of losing a good job. Other opportunities for Marcus were very limited, and his PSS offered to help Marcus find a temporary job at a nursing home where he had previously worked. The pay for this job was much lower than Marcus’s previous position at the VA, and Marcus was not sure he could get by on the reduced income. In fact, he almost did lose his apartment, but his PSS helped him keep his head up, pointing out that the job in the nursing home was “a step down in wages, but a step up in humility.” His PSS also encouraged him to learn from his experience, suggesting that “he was being tested on the little things before he could go back to the bigger things.” This particular PSS drew from his own experience working at the nursing home for nine dollars an hour, explaining to Marcus the new perspective he had gained. He told Marcus, “you must have gratitude for what you are accomplishing now,” rather than dwelling on the past. “You depleted your 401K to get high, and you’re not going to get that back,” he said. Yet he helped Marcus realize that he would have to take things slowly in rebuilding his finances and helped him use his limited income to his advantage. The PSS also worked with Marcus to develop a budget that took into account his reduced wages. After reducing his spending to account for his reduced wages, Marcus was able to consistently pay his rent and keep his apartment.

- **Addressing Stigma.** While reports indicate that mental illness and substance abuse problems are widespread, stigma continues to be a prominent problem for individuals with those disorders during recovery (Corrigan, 2004; NAMI, 2010) and has been linked to an increased risk for negative outcomes, which include reduced employability, imprisonment, and homelessness (Browne, 2007; Corrigan, et al., 2007; McNiel, et al., 2005). As such, stigma is a barrier that may impede treatment and recovery goals integral to the HUD-VASH program. Traditionally, stigmatization has been defined as the process by which individuals who lack certain characteristics or traits belittle other individuals who have them (Piner & Kahle,

1984); however, stigma has further been broken down into two critical components: public and self-stigma. Public stigma occurs when there is a reaction toward a specific group of individuals who share a negatively viewed trait (Corrigan, 2004), while self-stigma results from one's own reactions toward oneself due to membership in a stigmatized group (Corrigan & Watson, 2002). Moreover, self-stigma has been associated with decreases in self-esteem and self-efficacy, which may hinder motivation toward participation in activities that would promote recovery (Corrigan, et al., 2006), such as applying for a job or approaching a landlord for a housing application after one or more failed attempts. Although public and self-stigma can be viewed as separate, it is important that PSSs consider both, as each of these components often acts together and builds upon each other. For example, if a Veteran with COD encounters a landlord who is hesitant to rent to them due to their diagnoses (public stigma), he/she may internalize this stigma (self-stigma), which in turn may negatively impact perceptions of his/her own capabilities and decrease his/her motivation toward approaching another landlord with a new housing application. However, PSSs who can identify with "their" Veterans may provide an essential safeguard that helps prevent the negative consequences of stigma cited above by using two key strategies: contact and education (Corrigan, 2004).

Contact. Contact usually involves face-to-face interactions with individuals from the stigmatized group and has sometimes been paired with brief education programs that have been associated with changes in stigmatizing behavior (Corrigan, 2004). Unique to the PSS model is the opportunity to combat self-stigma in Veterans struggling with recovery by providing regular contact with a positive role model. This has two benefits. First, participating Veterans have an opportunity to witness that another Veteran with a mental illness and substance abuse disorder can be successful (dispelling the myth that this group cannot succeed). Second, Veterans can learn concrete

strategies from those who have faced and successfully overcome the challenges of stigma while working toward recovery.

Education. Having direct access to a contact or role model that they can turn to may not only serve to combat negative reactions toward the self, but may replace these same reactions with hope. Furthermore, PSSs can share the knowledge that they acquired through their own similar experiences to educate the Veteran on how to best approach these and other similar situations in which the Veteran feels stigmatized. In this way, PSSs can help divert otherwise potentially debilitating outcomes associated with stigma. PSSs are encouraged to check in with Veterans to assess and address any issues surrounding stigma that may ultimately impede recovery, as they may not always be directly reported by the Veteran. In addition, as Veterans make their way through the HUD-VASH program, they will experience varying degrees of progress in comparison to other Veterans. PSSs are encouraged to monitor and address any situations involving stigma among Veterans in order to promote a safe environment where each Veteran can continue to share, grow, and progress comfortably at his/her own pace. Due to their unique role, PSSs are also encouraged to monitor and address any issues regarding stigma that may impede their own recovery with a source of support outside the program.

Training Peer Support Specialists

PSSs receive training from a number of sources. Some of the day-to-day informal training of PSSs comes from supervision regularly provided as part of the HUD-VASH program. The formal training in which the PSS participates should include internal training on program issues and operating procedures, certifications required by PSS's VA or affiliated/employing homeless program, as well as training for consumer-providers on mental health and COD provided by an outside agency. Additionally, PSSs have identified other areas in which training would be helpful and for which further training venues are being identified and/or developed.

Internal Training

In addition to basic orientation (such as timekeeping) offered to both CMs and PSSs, the HUD-VASH program will need to provide training to PSSs on a number of topics relevant to their job, including

- Confidentiality policies,
- Research and documentation policies,
- Crisis management, and
- Expectations of the position.

VA Stance on Training of PSSs

Currently, PSSs hired as official VA “Peer Support Technicians”² are required to “demonstrate competency” within one year of their hire. This could involve either taking and passing one of the approved peer certification courses mentioned above or passing the competency assessment developed by the VA. To support the training of VA Peer Support Technicians, the VA’s Office of Mental Health Services, Psychosocial Rehabilitation Section, will soon be releasing the VA’s Peer Support Training Manual. The manual was adapted from the 2007 National Association of Peer Specialists (NAPS) Training Manual with input from peer support practitioners across the United States. The manual will focus on the Peer Support Technicians’ competencies, which were derived from a synthesis of six prominent peer training and certification programs in the United States. It is anticipated that various staff all across the VA will use this Manual to develop a course for peer training.

Third-Party Training Nationwide

Currently, training for PSSs varies widely across the country in breadth, scope, and length, ranging from 30 hours to 28 weeks. One of the most highly regarded training programs is the curriculum developed through the Georgia Peer Support Certification Project. The Georgia program

²The current designation for PSSs in VA is Peer Support Technicians. However, the VA will soon be announcing the official creation of the Peer Support Specialist, or PSS, position. After that, the VA will have two peer positions, the PSTs and the PSSs. The PSSs will be more trained, have more experience, and receive a higher salary than PSTs.

is a comprehensive, classroom-based, 40-hour, 30-module curriculum covering peer support, psychosocial rehabilitation and recovery, the impact of diagnosis on self-image, effective communication skills, and the basics of documentation. In addition, the Depression and Bipolar Support Alliance (DBSA), which works in collaboration with staff from the Georgia Peer Support Certification Program, provides an on-site, classroom-based, 40-hour training program. Both training programs include an exam that requires a minimum score of 80 percent in order to pass the course.

Most existing programs offer at least 40 hours (a useful minimum standard for peer training) and include an exam. Other nationally recognized programs that have trained peers are Consumer Connections of the Mental Health Association in New Jersey, Recovery Innovations in Pennsylvania and Arizona, and the Transformation Center in Massachusetts. In addition, Katz and Salzer (2006) of the University of Pennsylvania Collaborative on Community Integration summarized the details of 13 peer training programs, all of which “certify” peers. Peer certification means that their services are reimbursable by state Medicaid programs. Many states, including Georgia, Arizona, Iowa, Michigan, North Carolina, Washington, Pennsylvania, District of Columbia, Wisconsin, Hawai’i, and Florida hire certified peers. Previous PSSs have also participated in the extensive training program offered through consumer-run programs affiliated with the University of Massachusetts Medical School and other agencies.

Training on the Critical Time Intervention (CTI) Model

Previous PSSs have also participated in training offered by the CTI Project at the Mailman School of Public Health of Columbia University. Given that this model is being viewed as central to the HUD-VASH program, this training is particularly helpful in ensuring that PSSs are able to work smoothly with CMs, with a common understanding of the foundations of this type of intervention for Veterans with co-occurring mental illness and substance abuse disorders.

Training for PSSs and Clinical Supervisors

PSSs and their supervisors should pursue continuing education. The VA offers a yearly conference for all PSSs and their supervisors. The National Association of Peer Specialists, Inc. (NAPS), a private, non-profit organization dedicated to peer support in mental health systems, offers an annual conference (see <http://www.naops.org/>). The U.S. Psychiatric Rehabilitation Association also sponsors a national conference and other training opportunities for peers (see <http://www.iapsrs.org/>).

Hiring Peer Support Specialists

Hiring and deploying PSSs can be complicated. Many HUD-VASH staff persons—i.e., the individuals who would be serving alongside a PSS—will not be familiar with PSSs. The information presented below serves as a guide for HUD-VASH teams as they are establishing the structure of the PSS role. However, it should be noted that there is more than one way to create an effective and sustainable PSS program. A PSS's job also may evolve over time—the job in its first year may look quite different two years later, but both may be equally effective. Our goal is to provide some general guidelines for hiring and deploying PSSs, though we wish to emphasize that staff development programs should be flexible, responsive to the organization and its customers, incorporate the ideas, and meet the needs of all employees. Working to get the input of employees involved (other HUD-VASH CMs and leaders) on how to structure the PSS role will go a long way to secure the full buy-in and support of leadership and staff. The following represents a first step towards guiding policy and practice development for those wishing to hire PSSs in HUD-VASH.

1) Hiring criteria: *What are appropriate hiring criteria for PSS?*

- Is a certain type of mental illness required, or not?
- Should the PSS be free of substance use? For how long?
- Should the PSS not have been hospitalized for some period of time?
- How should the above be documented?
- Is hiring “from within” a good practice or not?

It is essential for administrators to understand that the Americans with Disabilities Act prohibits employers from asking applicants about their medical/psychiatric conditions or history. Rather, the hiring criteria for PSS should be based on the knowledge, skills, abilities, and personal characteristics required to perform the duties of the position (examples of key competencies required by VA can be found below).

Position descriptions and recruitment announcements should describe the population served and the expectation that the Peers will utilize their own recovery experiences as a means of role-modeling successful community integration and providing peer support to foster achievement of Veterans' recovery goals. The VA already has a position description for a GS-5 (Peer Support Technician) and will soon be developing one for a GS-5-7-9 (Peer Support Specialist). Employment application forms and interview questions should be carefully designed to elicit the necessary information to determine if the applicant's training and personal experiences have afforded them the knowledge and skills necessary to successfully perform the duties of a PSS (examples of some suggested interview questions for the PSS position description are below).

It is generally recommended that organizations aggressively recruit individuals who are not currently, or who have not recently, received mental health services from the same organization in which they would be employed. Most organizations do not strictly prohibit this, and the negative impacts of doing so are minimized in large organizations where PSSs can be employed in a program that is remote from where they have recently received or currently receive their own mental health services. Should the selected candidate be one who currently receives services from the same organization, it is generally advised they make every effort to distance their personal service providers from their supervisor and direct co-workers. Under no circumstances should a supervisor also be that person's mental health services provider. PSS training and certification programs may have criteria that specify the need for particular types of diagnoses and/ or periods of sobriety or non-hospitalization; however, such criteria cannot legally be applied directly in the hiring process.

COMPETENCIES FOR VA PEER SUPPORT TECHNICIANS

Domain	Skills & Competencies
Personal Self-Development	<ul style="list-style-type: none"> Development of personal story Personal strengths Managing personal recovery Facing one's personal fears Managing one's own self-talk and combating negative self-talk.
Recovery	<ul style="list-style-type: none"> Components of recovery Stages of recovery Peer support role in PSR
Peer Support Principles	<ul style="list-style-type: none"> Being a role model Instilling hope Being an advocate Principal duties of peer support staff
Cultural Competence	<ul style="list-style-type: none"> Understanding how roles of ethnicity, race, spirituality, gender, sexual orientation, local community and other sub-cultures may influence recovery.
Communications Skills	<ul style="list-style-type: none"> Effective listening & asking questions skills Communication styles (pass/agg/assert.), and Verbal and Nonverbal communication Conflict resolution skills
Group Facilitation Skills	<ul style="list-style-type: none"> Basic understanding of group dynamics and interactions How to use support groups
Addressing Stigma	<ul style="list-style-type: none"> Managing internalized stigma
Understanding Illness	<ul style="list-style-type: none"> Major psychiatric conditions in DSM IV
Recovery Tools	<ul style="list-style-type: none"> Using recovery workbooks and other self help instruments Problem solving, using solution focused strategies Telling your personal recovery story, being mindful of who you're addressing Knowing community resources Self-help groups Writing recovery goals & plans Motivating people to use their dissatisfaction with their lives as an opportunity to create the one they'd like. Teaching how to manage self-talk and combating negative self-talk Facing one's fears
Professional Development & Workplace Skills	<ul style="list-style-type: none"> Ethics Boundary issues and dual relationships Working effectively with professionals on an interdisciplinary team Working with your supervisor
Managing Crisis and Emergency Situations	<ul style="list-style-type: none"> Early warning signs and symptoms that an illness is worsening Crisis prevention, using resources early

2) Confidentiality: *Is there a different level of confidentiality for PSSs than for other service providers? Does everything that gets stated to a PSS by a Veteran automatically get transmitted to the rest of the team?*

PSS are members of a treatment team. As such, they are expected to help the Veteran share information with the rest of the team that is pertinent to the team's effort to support the Veteran's treatment/recovery goals. In the case of critical information conveyed in peer support groups (which are confidential by their nature), the PSS would generally raise discussion with the Veteran outside of the peer support meeting as a means of processing with the Veteran the value and importance of including the team in addressing the issue. Should the Veteran refuse to share information with the team that is deemed vital to their safety, the PSS would be expected to inform the Veteran that they must (and will) convey such information to the team anyway.

3) Fraternalization: *Can PSSs spend time with their Veterans after hours? What are the boundaries of Veterans and PSSs giving money to each other? Can a PSS buy a Veteran a cup of coffee or not?*

PSSs are staff of the mental health system in which they are employed, and any organizational policies regarding financial transactions, intimate relationships, etc. that apply to other providers would also apply to the PSS. The fact that PSS may more often live, socialize, attend meetings, etc., where Veterans are likely to be does not change organizational policies designed to protect both the mental health system employee and the Veterans served by that system.

Most all friendships outside of the work environment have the potential to influence behaviors within the work setting and should therefore be avoided. PSSs are, however, likely to have more social contact with Veterans than traditional healthcare providers, as peers have a more mutual relationship with Veterans in the context of their work. It is therefore recommended that there be a safe environment for PSSs to discuss these situations with their supervisor as they may arise, to include assistance with discussing healthy boundaries with Veterans.

Like all employees (and perhaps even more so), it is important that PSS balance and have a healthy separation between work and personal life. Where a strong personal friendship may have previously been established between a PSS and a new Veteran coming into the program, the PSS (as would be expected of a Case Manager as well), should disclose this relationship with the clinical supervisor, and every effort should be made to assign that Veteran to a different PSS. Where assignment to another PSS is not possible, the employee and the supervisor should discuss appropriate boundaries to minimize real or perceived conflicts of interest that could jeopardize the PSS/ Veteran relationship and goals of the program.

4) Supervision/performance appraisal: *How does a supervisor appraise performance of a PSS?*

Performance standards for PSSs should be developed based on the work of the position, as with any other staff member. In the case of PSS, the supervisor's appraisal should focus on the PSS's effectiveness in developing supportive relationships with Veterans that foster successful personal and community integration skills and the development of natural supports.

5) Sick leave policy: *One of the top concerns organizations may have about PSS is what will happen if the PSS relapses. Should special sick leave policies be in place for them?*

The sick leave policy should be no different for a PSS than for any other employee. Employers should not probe for personal medical information, nor require medical documentation beyond existing organizational policies that apply to all employees. A PSS, like other employees, should be oriented, as a part of general employment orientation, to rights and responsibilities under the American's with Disabilities Act. As such, they should be advised that they may wish to identify themselves as persons with a disability/disabilities who require accommodation. If this is the case, it would be advisable for supervisors to consult with their human resources office or organization's legal counsel.

6) Disclosure of mental health status: To what extent is a PSS required to disclose his/her personal history of mental illness/addictions in the context of their work with Veterans?

Unlike more traditional mental health providers, such as social workers, psychologists, etc. who may also be (and disclose their personal experience as) consumers of mental health services, the unique role of the PSS requires them to do so. Their training as a PSS should comprehensively address how to utilize their own experiences effectively, so as to connect with, empathize with, and support Veterans. PSS training also generally includes learning to “tell one’s story” from a recovery versus an illness perspective, and how to ensure that their self-disclosure is pertinent to the situation and does not dominate the conversation. Under no circumstances should a PSS feel compelled to disclose aspects of personal experiences that he or she feels uncomfortable sharing.

Sample interview questions pertinent to PSS position:

- 1) The position you have applied for is a Peer Support Specialist. Please describe what you believe a peer support specialist’s role should be and what you would envision yourself doing in this role. Give an example of how you have provided this type of service in the past.
- 2) Please share a couple of specific examples of progress you’ve made in personal and/or work life where you experienced a setback or challenge and then turned the situation around to a positive outcome.
- 3) Please provide specific examples of how you have provided informal or formal support to one or more of your peers.
- 4) Please discuss a specific time when you had to negotiate with a group of people to obtain their cooperation. Tell us specifically who you negotiated with and what the outcome was. What did you learn from the situation?
- 5) Think of a time when you had to communicate something that you knew the other person

did not want to hear. How did you go about communicating it? What was the outcome?

- 6) Please describe a time when you assumed a leadership role (in any context). What sort of problems came up? What did you learn about yourself?
- 7) What was the most recent skill that you set out to learn? How did you go about it?
- 8) Give an example of an important goal that you have set for yourself in the past. What did you do to reach it? How did you measure your success in reaching that goal?
- 9) On a scale of 0 (lowest) to 10 (highest), please rate your personal knowledge in the following areas and give examples of how you have acquired and utilized this knowledge:
Knowledge of community resources _____
Knowledge about mental health and addiction problems _____
Knowledge of the VA Healthcare System _____
Knowledge of recovery issues and processes _____
- 10) How does being a peer support specialist in the HUD-VASH program fit in with your life goals for yourself? Please be specific.

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Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your knowledge about peer support.

- 1) HUD-VASH leadership is recommending that Peer Support Specialists be deployed within HUD-VASH teams.
- 2) Centers for Medicare and Medicaid Services stated that peer support – specifically the type of peer support that is provided by a PSS – is an “evidenced-based mental health model of care.”
- 3) The role of PSS is not incorporated until a Veteran has moved into housing.
- 4) While Case Managers often make home visits, PSSs do not engage with Veterans in their homes.
- 5) PSSs can accompany Veterans to 12-step sessions and reinforce the work Veterans have done with any other treatment providers they may have.
- 6) Each HUD-VASH team is limited to one PSS.
- 7) PSSs are often called upon when Case Managers are having a difficult time engaging a Veteran.
- 8) When a PSS discusses issues of clinical significance with Veterans, the PSS should encourage the Veteran to also share this information with the Case Manager.

- 9) When conflicts arise between the PSS and the Case Manager regarding the care of a Veteran, the issue should be raised with the Supervisor.
- 10) Most friendships outside the work environment have the potential to influence behaviors within the work setting and should therefore be avoided. PSSs are, however, likely to have more social contact with Veterans than traditional healthcare providers and should discuss how to establish healthy boundaries with their supervisors.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) Keeping roles and communication clear between Case Managers and PSS requires dedicated effort. Can you name a number of activities that the two might share? Which activities are exclusive to a Case Manager? Which are primarily handled by a PSS?
- 2) One role that PSSs can play very well is to lead groups for Veterans. What types of groups might a PSS lead on your team?
- 3) MISSION-Vet is a tested program specifically developed to target the mental health, substance abuse and related issues facing homeless Veterans through assertive outreach, psycho-education, linkages to community-based resources, and peer support. What are some peer support session topics recommended by MISSION-Vet?
- 4) One of the hallmarks of peer support is that it is generally available when more traditional services are limited and when Veterans are most in need of natural support and opportunities for social connectedness. How can the role of the PSS on your team be structured to be available when other supports are not?
- 5) Take a second look at the examples of peer support in action at the end of this chapter and discuss them with your team members.
- 6) What types of stigma exist for homeless people and people in recovery? How can PSSs help to address stigma, and how can they protect themselves from its negative consequences?
- 7) What kinds of internal and national training and conferences are available for the PSSs on your team?
- 8) Hiring and deploying PSS can be complicated because many HUD-VASH staff persons will not be familiar with PSSs. How will your team hire a PSS and establish the structure of this unique role?

HUD-VASH and HOUSING FIRST

What's in This Chapter?

Pathways Housing First (PHF) is a nationally recognized evidence-based intervention that is effective in stabilizing housing for individuals with complex histories of homelessness and multiple physical or mental health challenges to independent living.

In this chapter you will learn

- The principles of Pathways Housing First,
- How Housing First is critical to the principles of HUD-VASH,
- How PHF differs from traditional models, and
- How to implement PHF as part of your HUD-VASH program.

After reading this chapter, you will be able to apply many of the approaches and values of Pathways Housing First to your HUD-VASH program.

Overview

The main purpose of this chapter is to explain how Pathways Housing First (PHF), also referred to as HF, and HUD-VASH fit together, and how this synergy furthers both housing and recovery goals.

The central principle of PHF is that housing is not dependent upon a certain recovery threshold. Instead, individuals with mental or physical health care problems, who also may be suffering from substance use disorders, can use safe, stable, permanent housing as a platform from which to begin to pursue recovery or independent living goals. PHF does link clients with flexible supports

and treatment services, but these are secondary to shelter. In this model, housing is the first priority.

This chapter will describe how the HUD-VASH program and HUD-VASH Treatment Teams can implement and operate both housing and clinical services through a consumer choice model such as Housing First.

What is Housing First?

Housing First is a recovery-oriented, cost-effective approach to ending homelessness. What differentiates a Housing First approach from other strategies to end homelessness is that there is an immediate and primary focus on helping homeless individuals and families quickly access and sustain permanent housing. Within VA, Housing First centers on providing the most needy, most vulnerable homeless Veterans—who also have very low incomes, limited social resources, and serious, persistent issues that may include mental health and or medical complications—with housing quickly, then providing treatment and other supportive services as needed. This approach has the benefit of being consistent with what most people experiencing homelessness want and seek help to achieve; Housing First programs provide housing first and services second. The program is based on the belief that housing is a basic human right, particularly for those who have committed their lives to serving their country. An offer of independent, permanent housing must be made without strings attached. PHF, as it relates to HUD-VASH, holds that homeless Veterans with physical and mental health issues, including substance use disorders, require the fundamental safety and security that permanent housing provides, without first having to “earn” or

prove a readiness for housing by complying with or completing other treatment programs.

In addition to providing immediate access to safe, permanent housing, HF also offers the opportunity to connect with community-based, flexible support and treatment services through a case management or multi-disciplinary team approach. Such services need to be responsive to the individual and unique needs and goals of each Veteran. This fundamental shift to a person-driven (Veteran-centric), rather than a system-driven, approach provides the foundation for the program's success and for an individual's recovery.

Why Use the Pathways Housing First Model for HUD-VASH?

Pathway Housing First (PHF) is a nationally recognized evidence-based intervention¹ that is effective in stabilizing housing situations for individuals with complex medical histories and prolonged experiences of homelessness. It is an especially promising model for use with homeless Veterans in particular, whose willingness to accept assistance may be further complicated by strong survival instincts, tremendous personal pride, an uncompromising sense of self-determination, and a tendency to consider hardship within the context of the extremes of military service. Rather than asking a Veteran to compromise a sense of autonomy to accommodate larger bureaucratic systems, PHF embraces this resiliency by honoring the desire to live in a housing unit of one's own choice and by providing services that support independent living. Although at one point Veterans may have followed orders without question for the good of this nation, they now need individually tailorable, responsive services that can accommodate the direction and pace of their own recoveries. This approach is fundamental to PHF.

A key feature of PHF is that the program does not mandate participation in psychiatric treatment or necessitate sobriety as a condition for obtaining and maintaining housing. In eliminating these prerequisites, the PHF approach removes what can, to the most vulnerable homeless Veterans, be

insurmountable barriers. This is consistent with the HUD-VASH eligibility criteria—none of which include a set period of sobriety or absence of substance abuse history. In fact, through adopting a low-barrier approach to substance use as opposed to an abstinence based model, PHF has successfully tested the hypothesis that Veterans can move directly from homelessness into independent apartment living through the use of flexible, team-based support services. Based on previous research, it is expected that more than 80% of homeless Veterans—regardless of the severity of their mental health condition and addictions—can remain stably housed using the PHF program (Tsemberis et al, 2004).

PHF Program Model Development

PHF was designed in response to the requests of homeless individuals who expressed, as priorities, a single occupancy unit (for individuals without dependents) in a normal, community setting. An invitation to be placed in a home of one's own has proven to be an offer of enormous value that many who are living on the streets or in shelters find irresistible. We now know that the limited success of previous offers that bundle housing, services, and treatment together has more to do with what is being offered and less to do with one's mental health condition.

Traditional approaches

The PHF program model was born out of frustration with, and stands in stark contrast to, traditional approaches to homeless services in which treatment requirements and expectations of consumer stability have interfered with ending an individual's experience of homelessness. The underlying philosophy of traditional approaches is that change must occur at the individual consumer level before transition to permanent housing. Within traditional approaches, consumers must 'graduate' through a series of placements—typically starting with drop-in centers or shelters, moving through transitional housing, and, finally, into permanent housing—by demonstrating treatment compliance, psychiatric

¹ For more detailed information the evidence basis of Housing First, go to the <http://www.nrepp.samhsa.gov/>.

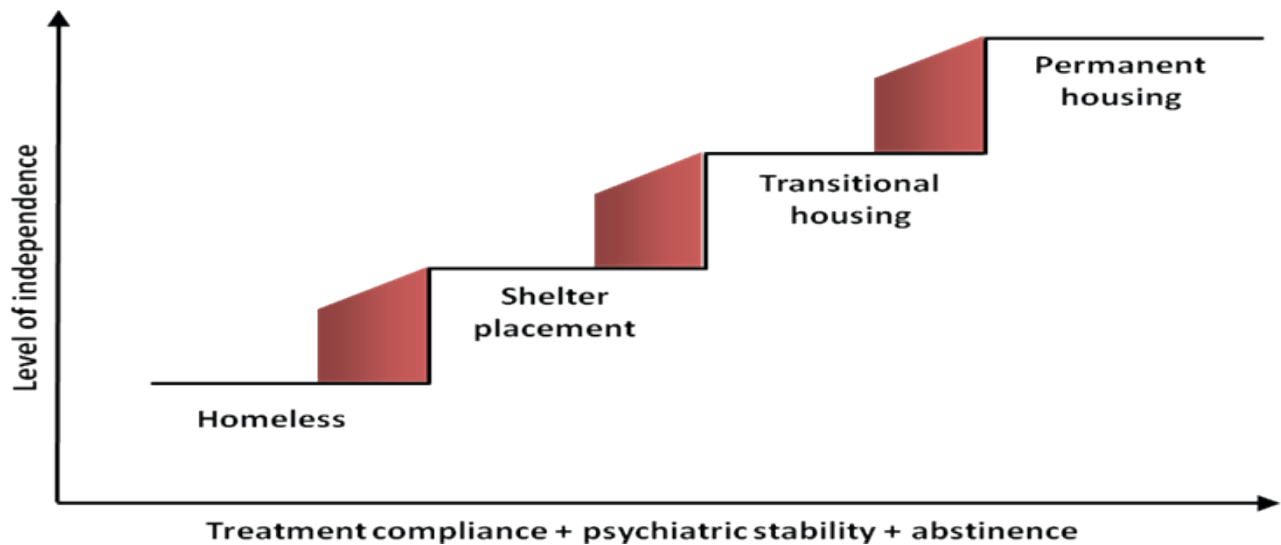


Figure 1. Traditional approach: a housing continuum in which housing independence increases as consumers demonstrate compliance, stability, and abstinence.

stability, and abstinence from substance abuse as depicted in Figure 1 (Henwood et al, 2010).

Within this stepwise approach, if a client relapses, becomes unstable, or chooses not to follow rules necessary for congregate living, he or she must leave the program and/or become institutionalized, which, by default, entails sacrificing their current living situation and the prospect of permanent housing. Within the approach, the motivation for change is believed to come from the promise of permanent housing. Yet, this structurally endorsed incentive creates a high stakes proposition, in which an end to homelessness depends upon an individual's ability to manage conditions that, by nature, are difficult to overcome and are often recurring. This may help explain why traditional service approaches have had only limited success addressing chronic homelessness.²

PHF's revised approach

In contrast, PHF starts with immediate access to permanent, scattered-site housing. There are three eligibility conditions: in addition to paying 30 percent of their income towards rent, Veterans must allow regular staff visits to their apartment, and agree to the terms and conditions of a standard lease with full tenant rights. The model attempts to avoid leveraging permanent housing in exchange for participation in treatment, and therefore creates a fundamental separation between permanent housing and clinical services. The use of such leverage can compromise a Veteran's strong sense of self-determination and autonomy and may increase the likelihood of blanket service refusal. In separating services, PHF effectively replaces the discussion of "earning" housing with the idea of a right to housing, as depicted in figure 2.

² For more information on the problem of chronic homelessness, go to U.S. Department of Housing and Urban Development, (2007). The Annual Homeless Assessment Report to Congress, Washington, DC.

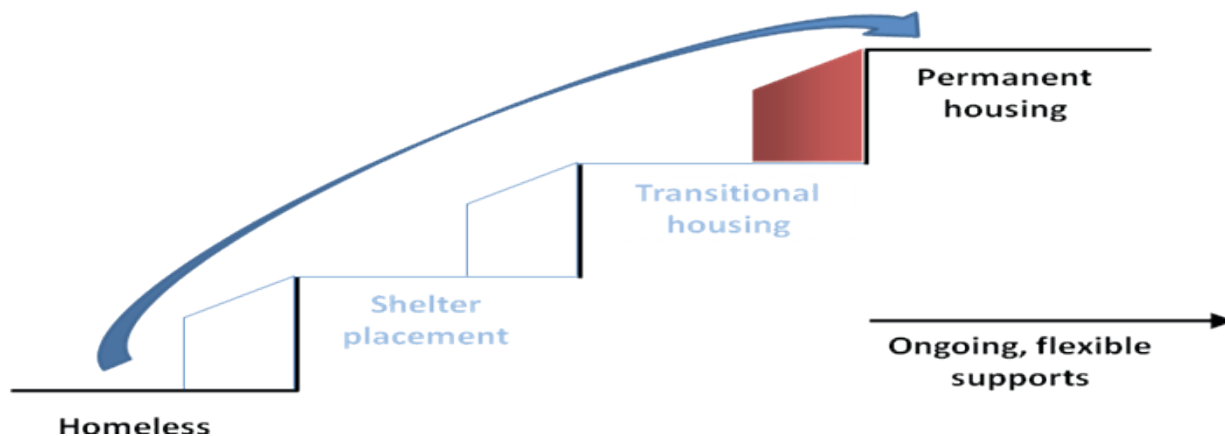


Figure 2. Housing First is a model that bypasses a housing continuum and provides immediate access to independent, permanent housing with flexible support services.

Four Essential PHF Program Principles

While offering a simple, straightforward solution to the issue of homelessness, the PHF program is a complex community mental health intervention that includes both a housing program and a services component. The program has numerous operational and administrative dimensions and protocols that are well defined.³ The focus here is to present four of the key program principles upon which this effective intervention is based:

- 1) Veteran-driven services
- 2) Separation and coordination of housing and case management/clinical services
- 3) Recovery orientation
- 4) Community integration

1) Veteran-driven Services

PHF's empirical basis and cost-effectiveness⁴, which has driven its rapid growth and

dissemination, often overshadows the consumer-driven service approach that has been the key to its success. Yet one of the reasons that PHF is so appealing to Veterans is that it places the Veteran in charge of the decision making. In contrast, most programs they have encountered in their pursuit of housing have been characterized by numerous rules regarding treatment, sobriety, curfews, overnight guests and other requirements. The PHF program puts the Veteran in control of the decisions-making process and supports the Veteran as s/he learns how to manage his or her own life.

Moving In. The starting point of the program is to ask Veterans what they want; the program begins by honoring and fulfilling the request that most people who are homeless say they want first — "A place of my own to live." (However, if the Veteran said he/she would like to live in a program with other Vets, the program would help them to apply.) From the start, the Veteran is making the decisions through staff questions, such as:

- Do you have a preference for neighborhood?
- Would you like a studio or a one bedroom?

³ For more information see Tsemberis, S. (2010.) *Housing First*. Minnesota, Hazelton.

⁴ For more information on the cost-effectiveness, see

- Are there other people in your life that you want to live with? What about pets?
- What type of furniture and household items can we provide?

In the PHF program, the Veteran is not enrolled in the program and placed into a vacant bed. Instead, Veterans should enter the program, set up their homes, and begin to build a life around their home.

Ongoing support. Honoring choice does not end with providing Veterans with apartments; ongoing services must also be “Veteran-driven,” which requires creative, flexible staff – both administrative and direct service providers – that can work to accommodate Veterans’ needs. Fortunately for such staff, providing a Veteran who is homeless with a rent-subsidized furnished apartment with few strings attached serves as an excellent way to achieve trust and begin a healing, collaborative relationship. That is, this offer of housing creates an opportunity, sets a precedent, and serves as an example for how all subsequent services will be provided.

2. Separation and Coordination of Housing and Case Management/Clinical Services

To be part of the PHF program, in addition to paying a percent of their income toward rent (which typically consists of VA benefits or Supplemental Security Income), Veterans must agree to only two conditions:

- 1) The terms and conditions of a standard lease with full tenant rights [housing component].
- 2) Regular staff visits to their apartment [services component].

While functionally separate, both the housing and services components of the program must communicate and be well-coordinated as described below.

Housing/Property Management. Given that the PHF program has a housing component, property management staff are essential. A major part of their responsibility is renting available units on the open market from private landlords, which eliminates the need for lengthy project planning and construction. It is crucial

to have the rental stipend or voucher in place before the program begins, or to have systems in place to expedite this process in order to guarantee immediate access to housing – a hallmark of the PHF approach.

The VASH Demonstration Project in the District of Columbia showed that the average time from referral to lease-up with a place to live can be reduced from 6 months to 1 month through Re-engineering housing eligibility and the leasing process, and Interagency cooperation and database sharing. The HCV application process was expedited through administrative support, such as collecting required documentation across governmental agencies (e.g. identification, eligibility, etc.); deputizing additional housing inspectors and appropriating funds for furniture and housing essentials. This allowed homeless Veterans to move in to their respective apartments within a month after initial engagement.

In addition, while HUD vouchers may fund rent payments, property management staff are responsible for making sure landlords receive their rent as well as invoicing Veterans for their portion of the rent. The program may offer to become a Veteran’s representative payee or offer other budgeting services to help ensure that bills are paid. Although program guidelines may vary regarding who can be designated as the representative payee, clinical, housing, and administrative services should be well coordinated to ensure a Veteran’s rent is being paid. Finally, property management staff must address ongoing maintenance issues by holding landlords responsible for maintaining their apartments and negotiating repair costs in the event of damages caused by the Veteran.

Support Services. Flexible support services are provided through a model that matches a Veteran’s need and for which funding can be secured. Given Veterans’ complex services needs, often services are provided through a multi-disciplinary team approach such as Assertive Community Treatment (ACT) or an intensive case management (ICM) team.

- Teams are located off-site, but are available on-call 24 hours a day, 7 days a week.
- Most services are provided in the community, at a Veteran's apartment, workplace, or neighborhood.

The choice of ACT or ICM teams is based on current best practices within mental health services and is limited by availability and sustainability of funding. The Veterans Integrated Service Network (VISN) and VA homeless programs will need to assess available resources vis-a-vis the needs of the Veterans when implementing an assertive or intensive model, matching the frequency and intensity of services with the needs of the Veteran. The addition of VA substance abuse specialists and cross training in co-occurring disorders is also a key ingredient to any HUD-VASH Housing First team.

At its core, however, PHF support services need to be flexible and promote Veteran choice. This has resulted in PHF's incorporation of peer support specialists in provider roles. Peer services are especially important since they help reduce inherent power differentials between Veterans and providers; this also provides consumers a hopeful reminder that recovery is possible. Integrating primary care and or mental health services through the VAMC, usually a nurse practitioner, has also become a priority given the prevalence of multiple and chronic physical health conditions.

In addition, as Veterans move through recovery, they may need fewer services. This can be accomplished by using an ACT step-down team or an enhanced case management team. This flexible adjustment process provides a better match between the Veteran and his or her service needs, increases program capacity, and reduces cost. When the Veteran is fully recovered, there is a complete separation of housing and services, because at this point, the Veteran continues to live in the apartment with no need for program services. The services component may simply be simply discontinued, avoiding the need for a potentially disruptive move.

Coordination of Program Components. Within PHF programs, housing loss occurs only for lease violations, not for treatment non-compliance or hospitalization. Some Veterans may lose their apartment after they relapse, stop paying bills, and are evicted by the landlord. However, because the housing component is separate from the clinical component, the Veteran who is separated from an apartment is not separated from the team's services; eviction from an apartment does not mean being discharged from the program. Rather than an end to the relationship, a Veteran's eviction becomes a learning opportunity on how to avoid future mistakes. Program staff continue to work with the Veteran through a housing loss, preventing a return to homelessness and ensuring continuity of care through crises.

Similarly, if a Veteran needs psychiatric inpatient treatment, he or she enters the VAMC, local hospital, or crisis stabilization unit, and upon discharge, returns home to the apartment. By separating the criteria for getting and keeping housing from a consumer's treatment status (yet maintaining a close ongoing relationship between these two components), HF programs help prevent the recurrence of homelessness when Veterans relapse into substance abuse or a psychiatric crisis. When necessary, team members can provide intensive treatment or facilitate admission to a hospital to address the clinical crisis – there is no need for eviction; after treatment, the person simply returns home.

3. Recovery Orientation

The PHF approach embodies a recovery orientation that is now the cornerstone of mental health service reform (New Freedom Commission on Mental Health, 2003). The rise of the recovery movement itself can be understood as addressing long held misconceptions that serious mental illness is a lifelong, crippling, degenerative condition (Hopper, 2007). Instead, research has shown that recovery is not only a possibility, but a reasonably attainable goal for persons with serious mental illness (Harding et al, 1987).

The PHF approach and value base embraces many aspects that are central to the recovery movement (Onken et al, 2007), including the following principles:

- Hope-instilling practice is crucial
- Relationships are foundational
- Opportunities/choices/options *really* matter
- Peer support and recovery role models are of primary importance
- People need knowledge and skills to self-manage their condition
- An emphasis on holistic wellness and positive lifestyle is healing

The PHF recovery orientation means that once Veterans have housing, they should continue to choose the type, sequence and intensity of services as much as possible (Salvers et al, 2007). Providers use a harm reduction approach when addressing substance use and mental health issues and incorporate a “stages of change” model within treatment (Prochaska et al, 1992), which recognizes that Veterans may choose to address different problems at different times in different ways.

While staff encourages increased participation in mental health treatment and supports a decrease in substance abuse, they must develop a non-judgmental stance since Veterans are not required to accept any formal clinical services such as taking psychiatric medication, seeing a psychiatrist, or working with a substance use specialist. Instead, Veterans choose their own treatment options and then learn whether these choices result in a life they value. Staff must learn to partner and collaborate with Veterans as they experiment with personal decision making, which constitutes a trauma-informed approach in which Veterans are empowered to regain a sense of control and security in their lives.

4. Community Integration

Government policies and judicial court decisions support the idea of recovery through a trend toward community integration and societal accommodation.⁵ The PHF accomplishes this

by providing housing in the form of scattered-site apartments, rather than congregate or institutional settings, and by providing flexible supports in a Veteran’s apartment, workplace, or neighborhood) rather than limiting access to facility-based settings. In short, the various settings for implementing the PHF program are not based on the campus of VAMC’s, transitional living in a VA Grant Per Diem Program, licensed residential treatment, or large congregate living facilities in the community with restrictive admission criteria; instead they are the same apartments available to any other person in the community.

Housing. Within the PHF program, Veterans have the same rights and responsibilities as all other tenants holding a standard lease. They are required to pay a percent of their income in rent. While Veteran-choice drives the provision of housing (location, type, etc.), housing and neighborhood choices are restricted by affordability and suitability of available units. To ensure the integration of Veterans into the community, particularly those with psychiatric disabilities, *the program limits leases to no more than 20% of the units in any one building so as not to create a ‘mental health’ building.* Apartments are rented at fair market value and meet HUD’s Housing Quality standards.

Services. Veterans agree to meet with program staff several times a month, including home visits, in order to maintain communication and identify any problems associated with independent living. Program staff encourage and foster normative relationships with landlords, neighbors, family, and other natural support networks that promote community living, with services tailored to the individual needs of each Veteran. A typical home visit consists of a conversation between the Veteran and the staff that provides an opportunity to assess the Veteran’s environment and general wellbeing, and, most importantly, services to maintain open channels of communication. Staff offer assistance with any domain the Veteran wishes to address from apartment repairs, to finding a job, to mending broken ties with family members.

⁵ Consider ADA, 1990; DHHS, 2003; Olmstead v.L.C., 1999

PHF Program Operations

While the PHF program principles outlined above describe much of the program, there are several important operational considerations worth highlighting, including home visits, the role of the clinical team in housing, and the use of interim housing.

Home Visits

The home visit represents the heart and soul of the program. It is a targeted clinical intervention where important communication takes place and where the change happens — in Veterans' and their families own environments. There is a lack of formal boundaries when making a home visit, and therefore it is essential that the staff always maintains clinical and ethical boundaries. Making a home visit provides an opportunity to make innumerable observations about a Veteran's life. In some ways, it is a very intimate experience, in that it allows a member of the treatment team access to the very center of the Veteran's life. Staff not only ask about, but actually observe, how a Veteran is managing and maintaining the living space; bedrooms, bathrooms and kitchens can provide enormous amounts of data to the trained observer.

Scheduling

In many ways, the home visit really starts *before* the actual visit. It begins as a discussion with the Veteran, and it continues while working out a time that is convenient for the Veteran. Spontaneous home visits should only be done if there are concerns that a client is in danger or hurt, and only after all other ways to contact the client have been exhausted. Building relationships, after all, takes time—especially when some Veterans are suspicious of a team's motives and are convinced that the team has the power to take the apartment away (the team does not have that power).

Providing Services

Home visits often include the provision of services such as medication delivery, counseling, and nuts-and-bolts activities. Much of the routine

conversation during a home visit centers around specific clinical services, instrumental or housing needs, scheduling new or follow-up appointments, family issues, safety, financial management, transportation, shopping and other areas discussed at length during the development of the treatment plan. During the early phases of the program Veterans may deny problems or troubling issues they are facing. To foster trust, team members must convey acceptance and concern—**not judgment**. Home visits can create an opportunity to connect and work on developing a deeper and more authentic relationship. To do this, HUD-VASH team members must be focused but not hurried or rushed. It is important to realize that

- Veterans will not open up and ask for help unless they first trust the staff member, and
- Unless Veterans trust the staff member, they may not be home when the visit occurs.

One of the interesting things about a home visit, however, is the way it creates a shift in power dynamics between client and staff. The home visit, after all, occurs on the Veteran's own turf. This, coupled with the PHF program philosophy that does not mandate participation in treatment as condition for keeping housing, poses an interesting challenge for the team member: Veterans will only welcome or tolerate a visit as long as they find it useful or engaging.

Gathering information

Successful home visits provide staff with an excellent opportunity to assess how someone is doing, as well as examine the condition of the apartment. Team members can learn an enormous amount about Veterans by carefully observing their living space.

- What is the meaning of the empty wine bottles on the kitchen counter?
- Who are the people in that new picture taped to the fridge?
- The shoes in the doorway are of a different size, who do they belong to?
- There are still no pictures hanging from these walls...does the person feel at home?
- Is that a new crack in the wall near the window?

The information obtained during a routine home visit can be stored, noted, asked about, used as a baseline for the client's *modus operandi*, or serve as a reason to intervene. Answers to these questions will inform the way the team approaches the client. This information is also crucial to preventing a possible housing crisis.

Clinical Team's Role in Housing

The clinical team works closely with the housing agency to ensure that an appropriate apartment is located. The clinical team attends every meeting, accompanies the client when he or she views apartments, and—after the client selects an apartment—the clinical team works with the housing authority to expedite the lease signing.

It is usually the clinical team that ensures that the apartment is fully furnished and is equipped with all that is needed, along with the set up of all utilities, prior to the client's move-in day. As previously mentioned, it is helpful to have agreements with furniture providers or local furniture banks for specific furniture packages. This ensures that furnishing the apartment does not slow the move-in process. The clinical team also ensures that the client's rent is paid on time every month, and the team works with the client to establish a monthly budget so that all utilities are paid in full on their due date. At times, this may make it necessary to become the client's representative payee if he or she is having difficulty prioritizing rent and utility payments.

Although the clinical and housing services provided to clients under the PHF model are separate, they are also complementary. It is essential for the housing staff and clinical staff to meet on at least a weekly basis, because it usually takes both teams to address problems as they arise. A frequent occurrence in an apartment is that something will break, such as a window, stove, or light switch. The clinical team or the client then alerts the housing staff, who then works with the building manager and the client to set up a time for this repair. This can go very smoothly if the teams are working well together, or it can become a great source of frustration and difficulty for the client if the housing and clinical teams are not well coordinated.

Another area requiring close communication is the tracking and reporting of responsibilities to governing authorities and funding agencies. The best way to do this is by maintaining frequent, clear communication between housing and clinical services. The need for seamless coordination cannot be emphasized enough. Clinical and housing staff must be open with each other about their concerns and priorities, and both teams must be committed to Housing First and client-driven care.

The Housing Process and Use of Interim Housing

One important part of the initial intake process involves determining the client's housing preferences. This is accomplished during the interview or by completing a housing preferences form that helps the client convey to staff what he or she likes and needs in an apartment. The client is asked about neighborhood location preferences, whether he or she needs special accommodations (such as grab bars in the bathroom), whether the ground floor or upper floor is preferred, and about other matters that will enable staff to help the client adjust to the new unit. Often, both the housing specialist (the staff person responsible for locating units) and a clinical staff member meet the client to discuss housing preferences. This information guides the search for the unit.

Clients are informed that, once a unit is found, they will be shown the unit to ensure it is acceptable to them before they commit to signing a lease. They are also informed that the unit will be furnished and they get to select the furniture, and they are given information concerning utilities and other household and lease issues.

Clients are provided with a time frame for the completion of the activities. The time frame provides an estimate of how long it takes to find a unit, meet the landlord, sign a lease, order furniture and complete all the other steps between intake and the move-in date. This time frame explains the process and helps clients manage their expectations about the process. In general, the entire process takes between two and six weeks.

Landlords sometimes request interviews with prospective tenants. In these cases, the staff prepares the client for the interview by posing

possible questions and reviewing the type of information the client should or should not disclose to the landlord.

Finding a safe, affordable apartment typically takes about two weeks, and clients are assured that they do not have to take the first apartment they are shown. They are usually given two or three apartments from which to choose, however, more often than not, clients select the first unit they are shown.

The use of interim housing is recommended when working with clients who are literally homeless and staying on the streets or in parks, train stations or other public places. Interim housing is also useful when the referring institution is a jail or prison and the client is about to be released.

Ideally, immediately after the client agrees to enroll in the PHF program, the ACT or ICM team is prepared to take steps and help the client exit from homelessness that same day. This can be easily and effectively accomplished if the program has an established relationship or agreement with the local YM/YWCA, motel, or other short-term housing setting and can pay for the client to stay in such interim housing until an apartment is secured. This type of interim housing has several advantages:

- The client gets some rest and begins to feel better.
- Team members gain the client's confidence that this PHF program can make things happen.
- Team members are viewed as trustworthy because they are true to their word.
- The client begins to believe that things might really change.
- Team members can easily locate the client the next day for follow up.

During this interim period, team members meet frequently with the new client to ensure that day-to-day needs are met. They address health issues; apply for benefits, identifications, or other needed documents; clear outstanding warrants or other legal issues; and attend to any number of other matters that need to be addressed given the enormity of the impending transition. While preparing for move-in day, discussions and activities usually focus on plans and expectations about the

new place, choosing and purchasing furniture, utilities, neighborhood amenities, safety, shopping, transportation, anticipation about people clients need to contact, or clients' concern about those left behind.

Interim housing is not an essential component of the program, and it may not be necessary if the client who is homeless is referred from an institution such as a psychiatric hospital or shelter. In these instances, it is possible to enroll the client into the program and begin the search for an apartment. The client can leave the institution with the PHF team, see and choose an apartment, and return to stay in the institution during the brief period that the apartment is prepared.

Conclusion

The success of the Housing First approach has resulted in its endorsement by the US Interagency Council on the Homeless, which include 15 federal agencies and several advocacy groups. In June 2010 the Council unveiled the nation's Five Year Strategic Plan to Prevent and End Homelessness (Opening Doors, 2010), with secretaries Donovan (HUD), Sibelius (HHS), and Shinseki (VA) presenting the plan. Secretary Shinseki's pledge to end homelessness for Veterans during the next five years included implementing Housing First as one of five major strategies endorsed by the Council.

The Housing First component of the HUD-VASH program is a natural evolution in a VA recovery-oriented program, since Veterans essentially drive their own care by utilizing the permanent Housing Choice Vouchers and accessing an array of services offered by HUD-VASH Case Managers, the local area VA Medical Center, or other community-based services. In order to end chronic homelessness among Veterans, the Housing First program will target those Veterans most in need of permanent housing, with co-occurring mental health and substance use disorders.

The VA HUD-VASH program will be expanded into a model that implements the key features of an Assertive Community Treatment (ACT) Model, or Intensive Case Management Model including an offer of treatment and vocational/employment

opportunities based on the preferences and needs of the Veteran over time. This will require organizational strategic planning, training and technical assistance at the Veterans Integrated Systems Network (VISN) level and local VAMC levels with support from the National Center on Homelessness among Veterans.

Through cooperation between HUD and VA, a Housing First approach can be realized for Veterans, many of whom have been homeless for years and who have been diagnosed with psychiatric disabilities, addiction disorders, acute and chronic health problems. In order to guarantee success, the program must adhere to fidelity to the PHF program model.

The program is committed to providing permanent housing and supports and is designed in a manner that provides each Veteran with multiple chances to succeed. The foundation of the program's success is rooted in its Veteran-driven approach. It is extremely successful in engaging Veterans since it offers housing and services on the Veteran's terms: it provides almost immediate access to one's own apartment without requiring treatment and sobriety as a prerequisite for housing. A well-trained, recovery-focused HUD-VASH case management and/or clinical support staff makes frequent house calls and supports the client to achieve their self-stated goals. While some Veterans move into their first apartment and manage well from the onset, others may need to live in two or three apartments before they can manage their lives and their housing effectively. The program does not give up; it makes a long term commitment to do everything possible to help the person leave homelessness and begin their journey of recovery.

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Test Your Knowledge!

Quick Check: Answer "true or false" to the following statements to check your knowledge about Pathways Housing First.

- 1) An offer of independent, permanent housing must be made without strings attached, and without expectations that Veterans must first demonstrate that they have earned this right to housing.

- 2) Once housed, PHF gradually begins to require participation in psychiatric treatment and/or sobriety as a condition of keeping housing.
- 3) It is expected that more than 80% of homeless Veterans—regardless of the severity of their mental health condition and addictions—can remain stably housed using the PHF program.
- 4) The PHF model requires only two conditions in addition to paying rent 1) regular staff visits to the apartment and 2) the terms and conditions of a standard lease with full tenant rights.
- 5) Peer services are especially important in PHF because they help to reduce inherent power differentials between Veterans and providers.
- 6) The PHF approach embraces many aspects that are central to the recovery movement.
- 7) PHF limits leases to no more than 20 percent of the units in any one building.
- 8) Some Veterans may need to live in two or three apartments before they can manage their lives and their housing effectively.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) The PHF model was born out of frustration with and stands in stark contrast to traditional approaches to homeless services in which treatment requirements and expectations of consumer stability have interfered with ending an individual's experience of homelessness. How does the underlying philosophy of traditional approaches differ from that of PHF?
- 2) What are four key program principles of Pathways Housing First?
- 3) In many ways, the home visit is the "heart and soul of the program." What are some concrete practices that can make home visits a tool in recovery and housing stabilization?
- 4) The PHF model strives to help clients exit from homelessness the same day they enroll in the program. This can be easily and effectively accomplished by having established relationships with nonprofits and businesses that provide nightly lodging. What are some of the advantages to this interim housing?

Working with VBA to assist Clients in Obtaining Benefits

What's in This Chapter?

There are a number of benefits that HUD-VASH Veterans may be entitled, but are not receiving, because of the instability of their lives while homeless.

In this chapter you will learn

- The different types of benefits,
- Which forms are needed for claims,
- How to file a claim, and
- What the Post 9-11 GI Bill and other GI Bills cover.

After reading this chapter, you will be familiar with the benefits for which Veterans on your caseload may be eligible, and you will be better prepared to help them access these benefits.

Getting Connected with VA Benefits

Homelessness among Veterans is a recognized issue across the nation, and the Department of Veterans Affairs (VA) has a duty to provide assistance to this population in need. VA has an obligation to ensure that Veterans who are homeless have access to VA benefits and are receiving the benefits they have earned.

VA provides several different benefits, such as financial assistance based on service-connected disabilities or need, employment services, housing assistance through a VA-guaranteed loan, and education/training. The purpose of this chapter is to provide key information and resources on VA benefits to aid in ending and preventing homelessness among Veterans.

What are the needs and interests of the Veteran who is experiencing homelessness?

- Income and financial support
- Employment and vocational services
- Housing assistance through a home loan guarantee or refinancing
- Education and training

Income and Financial Support

Compensation Benefits

Disability compensation is a tax-free monthly benefit paid to Veterans for disabilities, diseases, or injuries that happened during, or were aggravated by, active military service. The Veteran's discharge must have been under other than dishonorable conditions. The monthly amount paid is determined by the Veteran's level of disability.

Please see compensation benefit rate tables at <http://www.vba.va.gov/bln/21/rates/>.

Pension Benefits

Pension is an income-based monthly benefit paid to Veterans with honorable wartime service who are age 65 or older or who are permanently and totally disabled due to disability that is not related to military service. The Veteran's discharge must have been under other than dishonorable conditions.

Compensation benefit rate tables are available at <http://www.vba.va.gov/bln/21/rates/>.

VA Forms to Claim Compensation and/or Pension Benefits

Links to these forms are provided below for Veterans who choose to complete the forms in hard copy, whether via computer or by hand. The VONAPP

link, also below, is the link to an online benefits application portal. Each of these applications, along with instructions, is also available in the appendix of this *Resource Guide*.

VA Form 21-526 - Compensation and/or Pension

<http://www.vba.va.gov/pubs/forms/vba-21-526-are.pdf>

VA Form 21-526 EZ - Compensation only; see page one of the form for the EZ criteria

<http://www.vba.va.gov/pubs/forms/VBA-21-526EZ-ARE.pdf>

VA Form 21-527 - Pension only

<http://www.vba.va.gov/pubs/forms/VBA-21-527-ARE.pdf>

VA Form 21-527EZ – Pension only; please see page one of the form for the EZ criteria

<http://www.vba.va.gov/pubs/forms/VBA-21-527-ARE.pdf>

VA Online Application (VONAPP) – Compensation and/or Pension

<https://www.ebenefits.va.gov/>

If the claimant has already filed an initial claim for compensation, he/she may use VA Form 21-4138, *Statement in Support of Claim*, or any sheet of paper to do the following:

- Claim new conditions for service-connection,
- Reopen a previous claim, and/or
- Include VA Form 21-4142, *Authorization and Consent to Release Information to the Department of Veterans Affairs*, in order to allow the Regional Office to request records from a private facility. This form is available at <http://www.vba.va.gov/pubs/forms/VBA-21-4142-ARE.pdf> and in the appendix of this *Resource Guide*

VA Form 21-4138 can be found at

<http://www.vba.va.gov/pubs/forms/vba-21-4138-are.pdf>; it is also included in the appendix at the back of this *Resource Guide*.

The following documents may be submitted with the application/claim:

- Original or certified copy of the Veteran's DD-214 or official separation or discharge documents
- Medical evidence (doctor or hospital reports)
- VA Form 21-4142, *Authorization and Consent to Release Information to the Department of Veterans Affairs*, used for the Regional Office to request records from a private facility with the claimant's permission
- Dependency records (marriage and/or children's birth certificates)
- Service treatment records and other military documents
- Statements from the Veteran, witnesses, family members, etc. to support the claim
- Any other information in support of the claim

Ways to file a VA claim:

- 1) Apply online with the Veterans On-Line Application (VONAPP) through the eBenefits portal at <http://www.ebenefits.va.gov>.
- 2) Another option is to complete the application or claim and submit it to the nearest VA Regional Office, either in person or by mail. A list of locations is available at <http://www.vba.va.gov/bln/21/ro/rocontacts.htm>. If you choose to mail your paperwork, click on the links under "VA Regional Office."
- 3) Call 1-800-827-1000 for assistance.
- 4) Visit a VA Medical Center, clinic, or Vet Center.
- 5) Contact a Veterans Service Organization.
- 6) Contact the State/Territory Veterans Affairs Offices.

Employment and Vocational Services

Vocational Rehabilitation and Employment (VR&E) VetSuccess Program (Chapter 31)

The VR&E VetSuccess program assists Veterans with service-connected disabilities to prepare for, find, and keep suitable jobs. For Veterans with service-connected disabilities so severe that they

cannot immediately consider work, VetSuccess offers services to improve their ability to live as independently as possible. It is sometimes referred to as the Chapter 31 program.

Eligibility

To receive an evaluation for vocational rehabilitation services, a Veteran must

- Have received, or eventually receive, an other than dishonorable discharge, and
- Have a VA service-connected disability rating of at least 10% or a memorandum rating of 20% or more.

The law generally provides for a 12-year basic period of eligibility in which services may be used. The 12-year period begins on the latter of these dates:

- Date of separation from active military duty or
- Date the veteran was first notified of a service-connected disability rating

How to apply for Vocational Rehabilitation services:

- 1) Apply online with the Veterans On-Line Application (VONAPP) through the eBenefits portal at <http://www.ebenefits.va.gov>.
- 2) Complete and submit VA Form 28-1900, *Disabled Veterans Application for Vocational Rehabilitation*, <http://www.vba.va.gov/pubs/forms/VBA-28-1900-ARE.pdf>, which is also located in the appendix in the back of this *Resource Guide*. This can be submitted online, in person, or by mail. Mailing addresses are available at <http://www.vba.va.gov/vba/benefits/offices.asp> by clicking on the claimant's state of residency.

Process

A Veteran who is eligible for an evaluation under Chapter 31 and has applied for services must receive an appointment with a Vocational Rehabilitation Counselor (VRC). A Comprehensive Evaluation is completed with the VRC that includes

- A full assessment of the Veteran's interests, aptitudes, and abilities to determine whether the Veteran is "entitled" to VR&E services,
- An assessment of whether service-connected disabilities impair the Veteran's ability to find and/or hold a job using the occupational skills already attained, and
- Vocational exploration and goal development.

The VRC will help a Veteran found not to be entitled to services to locate other resources that address any rehabilitation and employment needs identified during the evaluation. Referral to other resources may include state vocational rehabilitation programs; Department of Labor employment programs for disabled veterans; state, federal or local agencies providing services for employment or small business development; internet-based resources for rehabilitation and employment; and information about applying for financial aid.

Housing Assistance through a Home Loan Guaranty or Refinancing

Home Loan Guaranty Service

The VA Home Loan Guaranty program helps eligible Veterans purchase, retain, and adapt homes. VA-guaranteed loans are made by private lenders, such as banks, savings and loan associations, and mortgage companies. When the loan is approved, VA will guarantee part of it, which protects the lender against loss up to the amount guaranteed by VA.

Eight Basic Steps for a Veteran to Obtain a VA-Backed Home Loan:

- 1) Find a realtor with whom to work.
- 2) Locate a lending institution that participates in the VA program.
- 3) Apply and obtain a Certificate of Eligibility. This can be completed online via eBenefits, through the lender, or by mailing VA Form 26-1880, *Request for a Certificate of Eligibility*, to the Eligibility Center in Winston Salem, NC.
- 4) Find a home to buy. The purchase and sales agreement should contain a "VA option clause"

and an “escape” from the contract without penalty in case the Veteran can’t get a VA loan.

- 5) Formally apply to the lender for a VA-backed loan. The lender will complete a loan application and gather the needed documents such as pay stubs and bank statements.
- 6) The lender orders a VA appraisal and begins to “process” all the credit and income information. (VA’s appraisal is **not** a home inspection or a guaranty of value. It’s just an estimate of the market value on the date of the inspection. Although the appraiser does look for obviously needed repairs, VA doesn’t guarantee the condition of the house. The appraiser, who is licensed, is not a VA employee.)
- 7) The lending institution reviews the appraisal and all the documentation of credit, income, and assets. The lender then decides whether the loan should be granted.
- 8) Finally, the closing takes place and the property is transferred. The lender chooses a title company, an attorney, or one of their own representatives to conduct the closing. This person will coordinate the date and time.

If the Veteran has any questions during the process that the lender can’t answer, the Veteran may contact VA at his/her closest regional loan center.

How to apply for home loan guaranty services:

- 1) **Apply online.** Go to the eBenefits portal (<http://www.ebenefits.va.gov>) and click on the My eBenefits tab towards the top, on the left side. It will open a screen with several benefit areas. On the bottom right of the screen is the Housing tab. You will need login credentials to request a Certificate of Eligibility (COE). If you have them, enter your Username and Password, if you need to request login credentials, you can simply click on the “Request/Activate a DoD Self-Service Logon” link which is shown below the area where you logon.
- 2) **Apply through the lender.** In many cases, lenders can obtain a Certificate online in minutes.

- 3) **Apply by mail.** Use VA Form 1880, <http://www.vba.va.gov/pubs/forms/vba-26-1880-are.pdf>, and return it to the address shown on the form. The form is also available at the back of this *Resource Guide*; however, if you would like a form mailed to you, call 1-888-244-6711 and follow the prompts for Eligibility.

Refinancing

Veterans with conventional home loans have options for refinancing to a VA-guaranteed home loan. Veterans who wish to refinance their subprime or conventional mortgage may do so for up to 100 pct of the value of the property. The loan limit is \$417,000. High cost counties have even higher maximum loan limits. VA County Loan Limits can be found at <http://www.benefits.va.gov/homeloans/>. Qualified Veterans can refinance through VA, which allows for savings on interest costs and avoids foreclosure. A VA refinancing loan also may help a Veteran who is facing a big payment increase.

Education and Training

- 1) Post 9/11 GI Bill (Chapter 33)
- 2) Montgomery GI Bill – Active Duty (MGIB-AD)
- 3) Montgomery GI Bill – Selected Reserve (MGIB-SR)
- 4) Reserve Educational Assistance Program (REAP)
- 5) Survivors’ and Dependents’ Education Assistance (DEA)

1) Post 9/11 GI Bill (Chapter 33)

The Post-9/11 GI Bill provides financial support for education and housing to individuals with at least 90 days of aggregate service on or after September 11, 2001, or individuals discharged with a service-connected disability after 30 days. Veterans must have received an honorable discharge to be eligible for the Post-9/11 GI Bill.

The Post-9/11 GI Bill will pay the individual’s tuition based upon the highest in-state tuition charged by a public educational institution in the state where

the school is located. The amount of support that an individual may qualify for depends on where they live and what type of degree they are pursuing.

This Post 9-11 GI Bill will pay eligible individuals:

- Tuition & fees directly to the school not to exceed the maximum in-state tuition & fees at a public Institution of Higher Learning. See chart listing maximum in-state tuition rates
- For more expensive tuition, a program exists which may help to reimburse the difference. This program is called the “Yellow Ribbon Program”.
- A monthly housing allowance based on the Basic Allowance for Housing for an E-5 with dependents at the location of the school.
- An annual books & supplies stipend of \$1,000 paid proportionately based on enrollment.
- A one-time rural benefit payment for eligible individuals.

Please refer to the Post 9/11 GI Bill website for updates and information on the upcoming changes to the Post 9/11 GI Bill program.

2) Montgomery GI Bill – Active Duty (MGIB–AD)

The MGIB program provides up to 36 months of education benefits. This benefit may be used for degree and certificate programs, flight training, apprenticeship/on-the-job training and correspondence courses. Remedial, deficiency, and refresher courses may be approved under certain circumstances. Generally, benefits are payable for 10 years following your release from active duty. This program is also commonly known as Chapter 30.

The monthly benefit paid to the individual is based on the type of training he/she takes, length of his/her service, his/her category, and if DOD put extra money in his/her MGIB Fund (called “kickers”). The individual usually has 10 years to use his/her MGIB benefits, but the time limit can be less, in some cases, and longer under certain circumstances.

3) Montgomery GI Bill – Selected Reserve (MGIB–SR)

The MGIB-SR program may be available to an individual if he/she is a member of the Selected Reserve. The Selected Reserve includes the Army Reserve, Navy Reserve, Air Force Reserve, Marine Corps Reserve and Coast Guard Reserve, and the Army National Guard and the Air National Guard.

The individual may use this education assistance program for degree programs, certificate or correspondence courses, cooperative training, independent study programs, apprenticeship/on-the-job training, and vocational flight training programs. Remedial, refresher and deficiency training are available under certain circumstances.

Eligibility for this program is determined by the Selected Reserve components. VA makes the payments for this program.

The individual may be entitled to receive up to 36 months of education benefits. Eligibility for the program normally ends on the day the individual leaves the Selected Reserves.

To qualify, the individual must meet the following requirements:

- Has a six-year obligation to serve in the Selected Reserve signed after June 30, 1985. If he/she is an officer, he/she must have agreed to serve six years in addition to the original obligation. For some types of training, it is necessary to have a six-year commitment that begins after September 30, 1990;
- Complete initial active duty for training (IADT);
- Meet the requirement to receive a high school diploma or equivalency certificate before completing IADT. (the individual may not use 12 hours toward a college degree to meet this requirement);
- Remain in good standing while serving in an active Selected Reserve unit. The individual will also retain MGIB - SR eligibility if he/she was discharged from Selected Reserve service due to a disability that was not caused by misconduct. The individual’s eligibility period may be extended if he/she is ordered to active duty.

4) Reserve Educational Assistance Program (REAP)

REAP was established as a part of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005. It is a Department of Defense education benefit program designed to provide educational assistance to members of the Reserve components called or ordered to active duty in response to a war or national emergency (contingency operation) as declared by the President or Congress. This program makes certain reservists who were activated for at least 90 days after September 11, 2001 either eligible for education benefits or eligible for increased benefits.

5) Survivors' and Dependents' Education Assistance (DEA)

Dependents' Educational Assistance provides education and training opportunities to eligible dependents of certain Veterans. The program offers up to 45 months of education benefits. These benefits may be used for degree and certificate programs, apprenticeship, and on-the-job training. If the individual is a spouse, he/she may take a correspondence course. Remedial, deficiency, and refresher courses may be approved under certain circumstances.

Eligible individuals must be the son, daughter, or spouse of

- A Veteran who died or is permanently and totally disabled as the result of a service-connected disability. The disability must arise out of active service in the Armed Forces.
- A Veteran who died from any cause while such service-connected disability was in existence.
- A Servicemember missing in action or captured in line of duty by a hostile force.
- A Servicemember forcibly detained or interned in line of duty by a foreign government or power.
- A Servicemember who is hospitalized or receiving outpatient treatment for a service connected permanent and total disability and is likely to be discharged for that disability. This change is effective December 23, 2006.

VA Forms for Education Benefits

VA Form 22-1990, *Application for VA Education Benefits*

<http://www.vba.va.gov/pubs/forms/vba-22-1990-are.pdf>

You may also complete and submit your application form online at www.gibill.va.gov. Click "Apply Online"; other resources are also available

VA Form 22-5490, *Dependents' Application for VA Education Benefits*

<http://www.vba.va.gov/pubs/forms/vba-22-5490-are.pdf>

You may also complete and submit your application form online at www.gibill.va.gov.

Rate tables for most education benefits can be found at http://www.gibill.va.gov/resources/benefits_resources/rate_tables.html

Additional Assistance

VBA Veterans Homeless Outreach Program:

Veterans experiencing homelessness and Veterans transitioning out of incarceration are the primary beneficiaries of the VBA's Homeless Veterans Outreach program. To reach a VBA Homeless Veterans Outreach Coordinator, call VBA's National Call Center at 1-800-827-1000.

VBA's National Call Center

1-800-827-1000

eBenefits

EBenefits is an online, self-service portal for Service Members and Veterans to access their personalized DoD and VA information.

Some key features of eBenefits include

- Check the status of compensation and/or pension claims,
- View payment history of received VA benefits,
- Obtain or submit an application for the home loan certificate of eligibility,

- Access MyHealthVet directly from eBenefits and vice versa,
- Access and retrieve copies of official military personnel records to include DD-214's and active/reserve orders.

Veterans may receive a premium eBenefits account at any VA Regional Office by presenting two forms of identification. A premium account can also be obtained through the in-person-authentication process for a MyHealthVet account at VA medical facilities.

Test Your Knowledge!

Quick Check: Answer “true or false” to the following statements to check your knowledge about working with VBA to assist clients in obtaining benefits.

- 1) VA has an obligation to ensure Veterans are receiving access to VA benefits and are receiving the benefits they have earned.
- 2) Disability compensation is a tax-free monthly benefit paid to Veterans for disabilities, diseases, or injuries that happened or were aggravated by active military service.
- 3) Veterans become eligible for pension benefits at age 60.

- 4) Veterans who are dishonorably discharged are eligible to receive an evaluation for vocational rehabilitation services.
- 5) Vocational rehabilitation services are sometimes referred to as Chapter 51.
- 6) The VA Home Loan Guaranty program helps eligible Veterans purchase, retain and adapt homes.
- 7) The Montgomery GI Bill has provisions for both Active Duty and Selected Reserve Veterans.
- 8) EBenefits is an online, self-service portal for Service Members and Veterans to access their personalized DoD and VA information.

Are you an Expert? Answer these questions on your own or with other members of your team.

- 1) What are the steps to filing a VA claim?
- 2) What are some ways that the Post-9/11/GI Bill is similar and different from other GI Bills?
- 3) What are some of the key features of eBenefits?

QUICK CHECK ANSWER GUIDE

Part 1	Chapter 1	Part 1	Chapter 6	Part 2	Chapter 3	Part 2	Chapter 8
#	Answer	#	Answer	#	Answer	1	TRUE
1	TRUE	1	TRUE	1	FALSE	2	TRUE
2	FALSE	2	TRUE	2	TRUE	3	FALSE
3	FALSE	3	FALSE	3	TRUE	4	FALSE
4	TRUE	4	FALSE	4	FALSE	5	TRUE
5	TRUE	5	TRUE	5	TRUE	6	FALSE
6	TRUE	Part 2	Introduction	6	FALSE	7	TRUE
7	TRUE	#	Answer	7	TRUE	8	TRUE
8	TRUE	1	TRUE	8	TRUE	9	TRUE
Part 1	Chapter 2	2	FALSE	Part 2	Chapter 4	10	TRUE
#	Answer	3	TRUE	#	Answer	Part 2	Chapter 9
1	FALSE	4	FALSE	1	TRUE	1	TRUE
2	FALSE	5	TRUE	2	TRUE	2	FALSE
3	FALSE	6	FALSE	3	TRUE	3	TRUE
4	TRUE	7	TRUE	4	TRUE	4	TRUE
5	TRUE	8	TRUE	5	TRUE	5	TRUE
	TRUE						
Part 1	Chapter 3	9	FALSE	6	TRUE	6	TRUE
#	Answer	10	TRUE	7	FALSE	7	TRUE
1	FALSE	Part 2	Chapter 1	Part 2	Chapter 5	8	TRUE
2	TRUE	#	Answer	#	Answer	Part 2	Chapter 10
3	FALSE	1	TRUE	1	TRUE	1	TRUE
4	TRUE	2	FALSE	2	FALSE	2	TRUE
5	FALSE	3	TRUE	3	TRUE	3	FALSE
6	TRUE	4	FALSE	4	TRUE	4	FALSE
7	TRUE	5	TRUE	5	FALSE	5	FALSE
8	TRUE	6	FALSE	6	TRUE	6	TRUE
Part 1	Chapter 4	7	TRUE	7	FALSE	7	TRUE
#	Answer	8	TRUE	8	TRUE	8	TRUE
1	TRUE	9	FALSE	Part 2	Chapter 6		
2	TRUE	10	TRUE	#	Answer		
3	FALSE	Part 2	Chapter 2	1	TRUE		
4	TRUE	#	Answer	2	TRUE		
5	TRUE	1	TRUE	3	TRUE		
6	TRUE	2	FALSE	4	TRUE		
7	FALSE	3	TRUE	5	FALSE		
8	FALSE	4	TRUE	6	TRUE		
9	TRUE	5	FALSE	7	TRUE		
10	TRUE	6	TRUE	8	TRUE		
Part 1	Chapter 5	7	TRUE	9	TRUE		
#	Answer	8	FALSE	Part 2	Chapter 7		
1	FALSE	9	TRUE	#	Answer		
2	TRUE	10	TRUE	1	TRUE		
3	TRUE	11	TRUE	2	FALSE		
4	FALSE	12	TRUE	3	FALSE		
5	FALSE			4	TRUE		
				5	FALSE		

Comprehensive HUD-VASH Assessment					
Housing and Homelessness History – Last 5 years					
Name/Location	Type	Start	End Date	Leaseholder	Reason for Leaving
<ul style="list-style-type: none"> Restrictions on location? Y or N Explanation 					
<ul style="list-style-type: none"> Ever evicted from public or subsidized housing? Y or N 					
<ul style="list-style-type: none"> Ever in foster care? Y or N 					
<ul style="list-style-type: none"> Barriers to housing stability? e.g., trouble budgeting, visitors create problems, involved in illegal activity, no experience as lease holder, history of violence 					
<ul style="list-style-type: none"> Housing plan 					
<ul style="list-style-type: none"> Housing goals 					
<ul style="list-style-type: none"> Motivation to obtain/maintain Housing 					
Employment History – Last 5 Years					
Employer	Position/Title	Wage	Start	End	Reason for Leaving
<ul style="list-style-type: none"> Employment goals 					
<ul style="list-style-type: none"> Currently receiving services? 					
<ul style="list-style-type: none"> Services needed to access or maintain employment 					
<ul style="list-style-type: none"> Motivation to obtain employment 					

Comprehensive HUD-VASH Assessment

Benefits and Entitlements

Income Receiving	Amt and End Date	Income Source	Amt and End Date
Unemployment Income		General Assistance	
Supplemental Security Income (SSI)		Retirement from Social Security	
Social Security Disability Income (SSDI)		Child Support	
Veteran's Disability Payment		Alimony or other spousal support	
Private Disability Insurance		Unemployment Insurance	
Worker's Compensation		Veteran's Pension	
TANF		Other (list):	
<ul style="list-style-type: none"> Plan to apply for or maintain income benefits 			
Noncash Benefits	Y or N		
Food Stamps	Y or N	TANF Child Care Services	Y or N
Medicaid	Y or N	TANF Transportation Services	Y or N
Medicare	Y or N	Other TANF-funded Services	Y or N
State Children's Health Insurance Pgm	Y or N	WIC	Y or N
Private Health Insurance	Y or N	Other: (list)	Y or N
<ul style="list-style-type: none"> Plan to apply for or maintain noncash benefits 			
<ul style="list-style-type: none"> Barriers to Obtaining/Maintaining Entitlements: 			

Debts

<ul style="list-style-type: none"> Credit status/score
<ul style="list-style-type: none"> Plan to pay off debts
<ul style="list-style-type: none"> Barriers to pay off debts
<ul style="list-style-type: none"> Services needed – pick list
<ul style="list-style-type: none"> Motivation to resolve credit/debt issues
<ul style="list-style-type: none"> Goals

Legal

<ul style="list-style-type: none"> Current probation/parole Status
<ul style="list-style-type: none"> Name of PO: _____ Date supervision ends _____
<ul style="list-style-type: none"> Felony history last 5 years
<ul style="list-style-type: none"> Incarceration history – last 10 years
<ul style="list-style-type: none"> Current involvement – e.g., engaging in criminal activity, current legal proceedings, outstanding warrants, subject to order of protection, etc.
<ul style="list-style-type: none"> Child support enforcement status
<ul style="list-style-type: none"> Services needed
<ul style="list-style-type: none"> Motivation to resolve legal issues

Comprehensive HUD-VASH Assessment

Education History

- Highest Grade Completed: Some HS HS Diploma or GED Some College Associate's Degree
 Bachelor Degree Technical Certification - Field: _____
 Other
- Current status In school Applying
- Education Goals
- Services Desired

Physical and Behavioral Health (including Trauma-related illnesses)

- Diagnosis: Medical, Mental Health, Substance Abuse, Mental Retardation – Include all axes
- Severity of each illness
- Treatment history for each diagnosis
- Names and contact info for all current service providers - Name, Organization, Phone #
- Describe how health issues impact housing stability
 paying rent disruptive behavior hoarding noise visitors
 Other: _____
- Current medications
- Adherence to medication regimen: Almost Always Sometimes Never
- If substance abuse diagnosis, current status and impact on functioning
 Actively using and not a problem Actively using and a problem Reducing use
 Abstinent: Date of Sobriety mm/dd/yy
- Frequency of Use: Daily Several Times Per Week Once a Week Less than 1X a Week
- Hospitalizations in last 3-5 years: dates, reasons, hospital names
- Detox in last 3 years: number of inpatient detox stays
- Services needed
- Motivation to use services:
- Current stage of change: pre-contemplation, contemplation, preparation, action, or maintenance
- Include narrative explanation

Family/Dependent Children

- Domestic violence/abuse history
- School attendance/performance of children
- Child custody
- Child care arrangements
- Special needs
- Children's services (foster care) Involvement – status, worker name and contact
- Current services providers and contact information
- Services needed
- Motivation to use services

Comprehensive HUD-VASH Assessment

Independent Living Skills/ Supports

- Status of ID for all household members
- Nature of social and familial relationships – identify supports and significant others, also identify negative influences and relationships
- History of seeking and using help/assistance
- Independent Living Skills Score

1 - Mostly Independent 2 - Needs Help Sometimes
3 - Needs Help Most of the Time 4 - Always Needs Assistance

1. Paying bills	1-4
2. Budgeting	1-4
3. Maintaining entitlements and other paper work	1-4
4. Maintaining a home	1-4
5. Preparing/obtaining meals	1-4
6. Travelling	1-4
7. Personal care/hygiene	1-4
8. English proficiency	1-4
9. Awareness of needs and knowing when to seek help	1-4
10. Able to access help when needed	1-4
11. Managing health/behavioral health needs and services, etc.	1-4
12. Taking medications	1-4
13. Keeping appointments	1-4
14. Discriminating danger/asserting and protecting self	1-4

Total score on Independent Living Skills (Range 14-56)

- Ability and motivation to improve skills:

Housing Stabilization Plan

Type of Plan: Initial Plan Update Date of Plan: From _____ to _____

Phase of Work: Housing Planning (Pre-Move) Phase 1: Transition
 Phase 2: Try Out Phase 3: Transfer of Care/Termination

Goals from Previous Housing Plan (If applicable)

Status/Achievements and Barriers

1

2

3

Long-Term Goal – What type of living situation does the Veterans envision for him/herself in 5 years, 10 years? :

Goals (for this assistance period)	Target Completion Date (mo/yr)	Case Manager Tasks	Veteran Tasks
Goal 1: _____ Check Area: Housing Financial Health/Mental Health Substance Use Family and Friends Life Skills		1. 2. 3.	1. 2. 3.
Goal 2: _____ Check Area: Housing Financial Health/Mental Health Substance Use Family and Friends Life Skills		1. 2. 3.	1. 2. 3.
Goal 3: _____ Check Area: Housing Financial Health/Mental Health Substance Use Family and Friends Life Skills		1. 2. 3.	1. 2. 3.

Case Manager Name:		Date:	
Case Manager Signature:		Date:	
Veteran Name:		Date:	
Veteran Signature:			
Supervisor Name:		Date:	
Supervisor Signature:		Date:	

Housing Barriers Assessment

This assessment aims to capture some common housing stability barriers facing homeless people and those at risk of homelessness. Some information may be unknown or people may refuse to answer. This is to be expected, although it would be preferable to have as much information as possible. The housing barriers screen can be used to develop the Housing Stabilization Plans for each household and for re-assessments for those that receive ongoing assistance.

Income

- No income
- Has income but it's below 30% of AMI
- Recent decrease in income
- Receiving unemployment or other income that is time-limited
- Sanctioned or timed out on TANF

Debts/Expenses

- Monthly obligations exceed monthly income
- Poor credit history
- Currently in bankruptcy
- Debts to the utility company

Employment

- No High School Diploma or GED
- Unemployed
- Currently in temporary or seasonal job
- Inconsistent work history – gaps in employment or frequent changes in jobs
- Lacks adequate transportation

Legal Issues

- Child support enforcement
- On parole
- On probation
- History of incarceration
- Felony within last 5 years
- Restrictions on housing location – e.g., sex offender, order of protection for DV
- Outstanding warrant(s)

Housing History

- Homeless in the last 12 months
- Multiple episodes of homelessness
- Chronically homeless
- One or two legal evictions
- More than 2 evictions
- Never had own lease
- Lack of rental history of more than 1 year
- Does not have landlord references
- History of eviction from subsidized housing
- History of institutional care – e.g., state hospital, foster care, prison

Family Status

- Custody of 3 children
- Custody of 4 or more children
- 1 or more custodial children < age of 5
- Single adult under age 22
- Head of household under 25 years old with children or pregnant
- Current/past involvement with foster care
- Unmet child care needs
- Domestic violence survivor
- History of violence
- Has child with special needs
- Children not attending school regularly

Health/Disability

- Chronic physical illness
- Health crisis, detox or hospitalization in past year
- One disabling condition such as mental illness, SA
- Multiple disabling conditions
- Disabling condition has negatively affected housing stability
- Not in treatment for ongoing health issue(s)

Supports/Independent Living Skills

- No or limited support networks
- History of being unable/ unwilling to seek help
- Hoards
- Engaged in ongoing abusive relationship
- Limited English proficiency/literacy
- Never had driver's license
- Any household member is lacking Government Issued ID

Sample Case Manager Job Description for the Delivery of Housing Stabilization Services using Critical Time Intervention¹

DUTIES AND RESPONSIBILITIES:

The primary responsibility of the HUD-VASH case manager is to assist each Veteran and their families participating in the HUD-VASH program to access and maintain both housing and needed services and supports that will assist them to stabilize in their communities. The HUD-VASH program is committed to serving chronically homeless and vulnerable Veterans and each case manager is charged with increasing access to the program for this population.

As a member of the team, the HUD-VASH case manager will carry a caseload of approximately twenty five to thirty five assigned Veterans and their families who have been identified as meeting the criteria for HUD-VASH services. HUD-VASH case management services will be guided by the tenets of Critical Time Intervention (CTI) as well as other evidence based practices and will include, but not be limited to the following activities: engagement, building rapport, assessment, service and support referrals, housing access, and follow-up housing stabilization and retention services. Responsibilities will also include keeping accurate records as well as working as an advocate for the individuals on the caseload in order to obtain appropriate services, care and housing.

HUD-VASH Case Management

- 1) Establish ongoing relationships with chronically homeless, VASH eligible Veterans, utilizing motivational interviewing techniques and pro-active engagement strategies
 - a. Maintain regular contact with identified Veterans and their families.
 - b. Identify housing preferences and barriers to access and retention
 - c. Identify issues of concern/need and address as appropriate

- d. Discuss short and long-term goals with individual, develop and document plan to meet them
 - e. Begin the housing planning process with each Veteran
 - 2) Establish eligibility for the HUD-VASH program
 - a. Verify the Veteran's Status, eligibility for VA medical care, need for case management services
 - b. Follow the process for referrals, evaluation, and admission to the HUD-VASH Program, ensuring that eligible Veterans and their families are placed into the program.
 - c. Continue to provide appropriate treatment and supportive services to the potential HUD-VASH Program participants, assisting the Veteran in the PHA issuance of the rental voucher process.
 - d. Provide housing search assistance to the HUD-VASH Participants with vouchers.
 - 3) Conduct assessment, referral and provide follow-up services to individuals in appropriate treatment, supportive and other programs both VA based and in the community.
 - a. Learn about the Veteran's (and family's, if applicable) treatment, housing and support history. Discuss what worked, what didn't and why.
 - b. identify and prioritize needed services and target most appropriate options.
 - c. Assess barriers to housing stability and target interventions accordingly.
 - d. Develop a plan to access housing, services and supports. Actively involve the Veteran in the assessment and development of the housing plan.
 - 4) Work with individual to reach identified goals emphasizing self-determination, responsibility and respect.
 - a. Assist Veteran (family) with Housing location, ID, benefits, income, employment,

¹ Adapted from the Department of Veterans Affairs, VHA Handbook 1162.05. HUD-VASH Program. Washington, DC: 2009.

- education, health, legal and other issues to support stable tenancy and life goals.
 - b. Advocate for Veteran's (family's) needs as necessary within larger system of services and supports.
 - c. Arrange, coordinate care, and provide direct clinical services and support.
- 5) Once appropriate placement is achieved, utilize the three-phase critical time intervention model to work with Veteran (family) and service providers to maximize support community integration and housing stability.
- a. With the Veteran (family): Maintain close contact with Veteran throughout their transition to housing, including visiting the Veteran in their new home, and assisting the Veteran (family) in becoming familiar with their new community.
 - i. Provide direct services to the Veteran (family) while working to connect each with both VA and community resources.
 - ii. Provide direct mental health and substance use counseling within the scope of the practice and role as case manager.
 - iii. Meet regularly with landlords, PHAs and tenants to ensure a safe living environment and address any tenancy and/or subsidy issues.
 - iv. Provide crisis prevention and management services as need to maintain the Veteran (and family) safely in the community.
 - v. Monitor physical and mental health and substance use status and stability.
 - vi. Regularly discuss changes in psychiatric symptoms and/ or triggers for substance use
 - vii. Provide access to treatment resources and encourage re-entry into treatment.
 - viii. Work to improve life and tenancy skills by participating with Veterans in their new housing arrangements.
 - ix. Provide education on life skills such as: credit repair, financial literacy, shopping and maintaining a household, safety and tenancy requirements.
 - x. Facilitate Veterans participation in employment and training both within the VA and other community resources.
 - xi. Remain accessible and responsive to the Veteran and their families maintaining a focus on HUD-VASH plan
 - xii. Discuss Veteran's concerns, fears, and frustrations, and work to resolve or alleviate while challenging the individual (family) to address these potential obstacles of his/her long-term goals.
 - xiii. Make intensive efforts to locate missing clients.
- b. Work with the VAMC and Community providers and supports: carefully coordinate these linkages.
- i. Meet together with the Veteran (family) and providers to adjust the service plan. The plan is to be adjusted at 3 month intervals documenting progress towards greater independence and housing stability.
 - ii. Monitor linkages to ensure it is happening and the success or challenges. Intervene, when necessary and advocate on behalf of the Veteran (and family) to fill gaps in services.
 - iii. Arrange for or provide transportation for necessary appointments.
 - iv. Educate the providers about the HUD-VASH case manager's role with the Veteran and their family.
 - v. Share information with the providers and supports as appropriate respecting confidentiality.
 - vi. Establish and encourage ongoing communication between landlords, PHA, VAMC, community providers, and supports.

- vii. Observe and test the housing stabilization service plan. Update accordingly.
 - viii. Be prepared to step-down the case management services as Veterans and their families are more able to use other resources and increase independence.
 - ix. Make a plan for decreased services or transfer to non-HUD-VASH subsidies not requiring Case Management Services.
- 6) Document in a timely and accurate manner in the HUD-VASH file and the NEPEC system.
 - 7) Develop a broad familiarity of available treatment and supports that may be available to Veterans and their families. Ensure that all of the HUD-VASH team has access to the resources developed to support all Veterans participating in the HUD-VASH program.
 - a. Visit behavioral health treatment sites both within the VA system and in the community and know how to access them.
 - b. Know the behavioral health services available for persons with various needs, i.e. crises, medical complications, substance abuse issues chronic/low demand.
 - c. Attend ongoing training to learn new ideas in assisting persons with mental illness, substance abuse issues, and co-occurring disorders.
 - d. Develop expertise in assisting Veterans with benefits, legal, employment and educational opportunities.
 - e. Establish expertise in working with families, both living together and apart.
 - 8) Follow all Veterans Administration policies and procedures to maintain professional standards of the HUD-VASH program, safety of staff and those we serve.
 - a. Participate as a full team member
 - b. Maintain strong relationships with community resources
 - 9) Participate in staff meetings, case conferences and individual supervision.
 - a. Consult with Supervisor and team on strategies for serving Veterans and their families.
 - 10) Maintain collaborative relationships with HUD-VASH team and VA staff, other service providers, and professional behavior toward the public.

Sample interview questions pertinent to PSS position:

- 1) The position you have applied for is a Peer Support Specialist. Please describe what you believe a peer support specialist's role should be and what you would envision yourself doing in this role. Give an example of how you have provided this type of service in the past.
- 2) Please share a couple of specific examples of progress you've made in personal and/or work life where you experienced a setback or challenge and then turned the situation around to a positive outcome.
- 3) Please provide specific examples of how you have provided informal or formal support to one or more of your peers.
- 4) Please discuss a specific time when you had to negotiate with a group of people to obtain their cooperation. Tell us specifically who you negotiated with and what the outcome was. What did you learn from the situation?
- 5) Think of a time when you had to communicate something that you knew the other person did not want to hear. How did you go about communicating it? What was the outcome?
- 6) Please describe a time when you assumed a leadership role (in any context). What sort of problems came up? What did you learn about yourself?
- 7) What was the most recent skill that you set out to learn? How did you go about it?
- 8) Give an example of an important goal that you have set for yourself in the past. What did you do to reach it? How did you measure your success in reaching that goal?
- 9) On a scale of 0 (lowest) to 10 (highest), please rate your personal knowledge in the following areas

and give examples of how you have acquired and utilized this knowledge:

Knowledge of community resources_____

Knowledge about mental health and addiction problems_____

Knowledge of the VA Healthcare System_____

Knowledge of recovery issues and processes

10) How does being a peer support specialist in the HUD-VASH program fit in with your life goals for yourself? Please be specific.

Program Improvement Tool

Section	Suggestion	Current Practice	Possible Improvements	Priority	Rationale for Priority

Project Planning Tool

Activities	By when will this be done? When will this occur?	Who is responsible?	Are any resources needed? Where will you get them?	Date Completed

Project Monitoring Tool

Activities	Monitoring Method	When will monitoring occur?	Who is responsible?

While these forms are publicly available, their inclusion here is intended to help the HUD-VASH team maintain momentum in connecting Veterans with the benefits and entitlements that may affect housing payments, disability claims, caregiver benefits, etc.

FULLY DEVELOPED CLAIM NOTICE

(Notice to Claimants of Information and Evidence Necessary to Substantiate a
Claim for VA Disability Live Compensation)

Thank you for participating in the Department of Veterans Affairs (VA) Fully Developed Claim Program. VA established the Fully Developed Claim Program to expeditiously process claims certified by the claimant or his/her representative as meeting the Fully Developed Claim criteria.

Fully Developed Claim Criteria:

1. For the purposes of this notice, your claim must be a rating-related claim for live compensation (original, secondary, and increased disability service connection claims only) submitted on VA Form 21-526EZ, Fully Developed Claim (Compensation).
2. You must submit, with your claim, the Fully Developed Claim Certification signed and dated by you or your authorized representative.
3. You must submit with the Fully Developed Claim Certification:
 - All, if any, relevant, private medical treatment records for the disabilities you are claiming and an identification of any treatment records from a Federal treatment facility such as a VA medical center.
 - For Guard and Reserve members, any and all Service Treatment and Personnel Records in the custody of your Unit(s).
 - If claiming dependents, a completed VA Form 21-686c, Declaration of Status of Dependents.
4. You must report for any VA medical examinations VA determines are necessary to decide your claim.

Note: VA forms are available at www.va.gov/vaforms

This notice is applicable to any and all conditions claimed for service connection with your Fully Developed Claim. Upon receipt of the Fully Developed Claim Certification, we will expedite your claim under the Fully Developed Claim Program. If it is determined that your claim does not meet the Fully Developed Claim criteria we will process your claim through our standard claim process.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

Generally, veterans are eligible to receive compensation for disabilities related to military service.

To support a claim for **service connection**, the evidence must show:

1. You had an injury in military service, or a disease that began in or was made permanently worse during military service, or there was an event in service that caused an injury or disease; **AND**
2. You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
3. A relationship exists between your current disability and an injury, disease, symptoms, or event in military service. Medical records or medical opinions are generally required to establish this relationship. However, under certain circumstances, VA may presume that certain current disabilities were caused by service, even if there is no specific evidence proving this in your particular claim. The cause of a disability is presumed for the following veterans who have certain diseases:
 - Former prisoners of war;
 - Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;
 - Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;
 - Veterans who were exposed to certain herbicides, such as by serving in Vietnam; or
 - Veterans who served in the Southwest Asia theater of operations during the Gulf War.

To support a claim for compensation based upon **an additional disability** that was caused or aggravated by a service-connected disability, the evidence must show:

- You currently have a physical or mental disability shown by medical evidence, in addition to your service-connected disability; **AND**
- Your service-connected disability either caused or aggravated your additional disability. Medical records or medical opinions are required to establish this relationship. However, VA may presume service-connection for cardiovascular disease developing in a claimant with a certain service-connected amputation(s) of one or both lower extremities.

If VA previously granted service connection for your disability and you are seeking an increased evaluation of your service-connected disability, we need medical or lay evidence to show a worsening or increase in severity and the effect that worsening or increase has on your employment and daily life.

To support a claim for service connection based upon a period of **active duty for training**, the evidence must show:

- You were disabled during active duty for training due to disease or injury incurred or aggravated in the line of duty; **AND**
- You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
- There is a relationship between your current disability and the disease or injury incurred or aggravated during active duty for training. Medical records or medical opinions are generally required to establish this relationship.

To support a claim for service connection based upon a period of **inactive duty training**, the evidence must show:

- You were disabled due to an injury incurred or aggravated during inactive duty training or suffered an acute myocardial infarction, cardiac arrest, or cerebrovascular accident during inactive duty training; **AND**
- You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable; **AND**
- There is a relationship between your current disability and your inactive duty training. Medical records or medical opinions are generally required to establish this relationship.

HOW VA DETERMINES THE DISABILITY RATING

When we find disabilities to be service connected, we assign a disability rating. That rating can be changed if there are changes in your condition. Depending on the disability involved, we will assign a rating from 0 percent to as much as 100 percent. VA uses a schedule for evaluating disabilities that is published as title 38, Code of Federal Regulations, Part 4. In rare cases, we can assign a disability level other than the levels found in the schedule for a specific condition if your impairment is not adequately covered by the schedule.

We consider evidence of the following in determining disability rating:

- Nature and symptoms of the condition;
- Severity and duration of the symptoms; and
- Impact of the condition and symptoms on employment.

Examples of evidence that you should tell us about or give to us that may affect how we assign a disability evaluation include the following:

- Information about on-going treatment records, including VA or other Federal treatment records, you have not previously told us about;
- Social Security determinations;
- Statements from employers as to job performance, lost time, or other information regarding how your condition(s) affect your ability to work; or
- Statements discussing your disability symptoms from people who have witnessed how the symptoms affect you.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant your claim, the beginning date of your entitlement or increased entitlement to benefits will generally be based on the following factors:

- When we received your claim;
- When the evidence shows a level of disability that supports a certain rating under the rating schedule or other applicable standards.

If you filed your claim with VA within one year of your separation from the military, entitlement will be from the day following the day you left the military.

Generally, payments are effective from the first of the month following the date of your entitlement or increased entitlement based on the above criteria.

Examples of evidence that you should tell us about or give to us that may affect how we determine the effective date of any benefits we give you on your claim include the following:

- Information about continuous treatment or when treatment began;
- Service treatment records in your possession that you may not have sent us; or
- Reports of treatment for your condition while attending training in the Guard or Reserve.

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

Fully Developed Claim Process

In order for you to participate in the Fully Developed Claim Program, you must obtain records and provide them to VA. VA will provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim. For this program, VA will only obtain service treatment records, and Federal treatment records when you identify them. If you serve or previously served in the Guard or Reserves, you must contact your unit to find out if they still maintain custody of your service records (including your medical records). If your unit currently has custody of your service records (including your medical records), you must get a complete copy of these records and provide them to VA.

If it is determined that other records exist, and VA needs the records to decide your claim, or if you do not provide us with your National Guard or Reserve records as described above, then your claim will not be processed as an Fully Developed Claim. Your claim will be processed in our standard claim process.

Standard Claim Process

VA is responsible for getting relevant records from any Federal agency that you adequately identify and authorize VA to obtain. These may include records from the military, VA medical centers (including private facilities where VA authorized treatment), or the Social Security Administration. VA will provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim.

VA will make every reasonable effort to obtain relevant records not held by a Federal agency that you adequately identify and authorize VA to obtain. These may include records from State or local governments, and privately held evidence and information you tell us about (such as private doctor or hospital records), or current or former employers.

WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable VA to obtain all relevant evidence not in your possession.

Fully Developed Claim Process

If you provide VA information sufficient to enable VA to obtain relevant service treatment records and Federal treatment records, if any, and you give VA all other records relevant to your claim, the claim may be decided under the Fully Developed Claim Process. This means that, if you are aware of relevant records that are not in your possession, you should obtain them and provide them to VA in order to participate in the Fully Developed Claim Process.

If your claim involves a disability that you had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before your entry into service.

WHAT YOU NEED TO DO *(Continued)*

Standard Claim Process

If you know of evidence not in your possession and want VA to try to get it for you, you must give VA enough information about the evidence so that we can request it from the person or agency that has it. If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. ***It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.***

If your claim involves a disability that you had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before your entry into service.

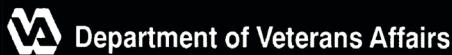
WHEN YOU SHOULD SEND WHAT WE NEED

Fully Developed Claim Process

Send the information and evidence with the Fully Developed Claim Certification. For this program, you must obtain and submit any and all Service Treatment and Personnel Records in the custody of your Guard or Reserve Unit. If we decide your claim before one year from the date we receive this claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support your claim.

Standard Claim Process

We strongly encourage you to send any information or evidence as soon as you can. If we do not hear from you, we may make a decision on your claim after 30 days. However, you have up to one year from the date we receive this claim to submit the information and evidence necessary to support your claim. If we decide your claim before one year from the date we receive this claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support your claim.



**VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)**

**FULLY DEVELOPED CLAIM
(COMPENSATION)**

IMPORTANT: Please read the Privacy Act and Respondent Burden on the back before completing the form.

SECTION I: TO BE COMPLETED BY VETERAN

1. VETERAN'S NAME <i>(Last, first, middle)</i>		2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	5. HAVE YOU EVER FILED A CLAIM WITH VA? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," provide your file number in Item 6)</i>		6. VA FILE NUMBER
7A. CURRENT ADDRESS Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country		7B. TELEPHONE NUMBERS <i>(Include Area Code)</i> Daytime _____ Evening _____ Cell phone _____	
8A. PREFERRED E-MAIL ADDRESS <i>(If applicable)</i>		8B. ALTERNATE E-MAIL ADDRESS <i>(If applicable)</i>	

9. WHAT DISABILITIES ARE YOU CLAIMING?

10. LIST VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION II: SERVICE INFORMATION

11A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES <i>(If "Yes," go to Item 11B)</i> <input type="checkbox"/> NO <i>(If "No," go to Item 12A)</i>		11B. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER	
12A. I ENTERED MY MOST RECENT PERIOD OF ACTIVE SERVICE ON _____ / _____ / _____ mo day yr		12B. BRANCH OF SERVICE	12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY
12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input type="checkbox"/> YES <input type="checkbox"/> NO		12E. PLACE OF SEPARATION	
13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. <i>(National Guard)?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," provide date of activation in Item 13B)</i>		13B. DATE OF ACTIVATION _____ / _____ / _____ mo day yr	
14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT?		14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? <i>(Include Area Code)</i>	
15A. DO YOU HAVE ADDITIONAL PERIODS OF ACTIVE SERVICE? <input type="checkbox"/> YES <i>(If "Yes," go to Item 15B)</i> <input type="checkbox"/> NO <i>(If "No," go to Item 16A)</i>		15B. I PREVIOUSLY ENTERED ACTIVE SERVICE ON _____ / _____ / _____ mo day yr	

SECTION III: MILITARY PAY

16A. DO YOU RECEIVE RETIRED PAY? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Item 16B)</i>		16B. TYPE OF RETIRED PAY? <input type="checkbox"/> LONGEVITY <input type="checkbox"/> DISABILITY <input type="checkbox"/> TDRL	
17A. DID YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE PAY? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Items 17B and 17C)</i>	17B. LIST AMOUNT <i>(If known)</i>	17C. LIST TYPE <i>(If known)</i>	
IMPORTANT: Unless you check the box in Item 18 below, you are telling us that you are choosing to receive VA compensation instead of military retired pay, if it is determined you are entitled to both benefits. If you are awarded military retired pay prior to compensation, we will reduce your retired pay by that amount. VA will notify the Military Retired Pay Center of all benefit changes.			
If you receive both military retired pay and VA compensation, some of the amount you get may be recouped by VA, or, in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.			
18. <input type="checkbox"/> No, I do not want VA compensation in lieu of military retired pay.			

SECTION IV: DIRECT DEPOSIT INFORMATION

Generally, all Federal payments are required to be made by electronic funds transfer (EFT), also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 19, 20 and 21 to enroll in Direct Deposit. If you do not have a bank account, we will give you a waiver from Direct Deposit, just check the box below in Item 19. The Treasury Department is working to make bank accounts available in such situations. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause a hardship if you enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street, Suite B, Muskogee, OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

19. ACCOUNT NUMBER <i>(Please check the appropriate box and provide the account number, if applicable)</i> <input type="checkbox"/> CHECKING _____ <input type="checkbox"/> SAVINGS _____ <input type="checkbox"/> I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT		
20. NAME OF FINANCIAL INSTITUTION <i>(Please provide the name of the bank where you want your direct deposit)</i>	21. ROUTING OR TRANSIT NUMBER <i>(The first nine numbers located at the bottom left of your check)</i>	

SECTION V: CERTIFICATIONS AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

22A. YOUR SIGNATURE <i>(Do NOT print)</i>	22B. DATE SIGNED
---	------------------

SECTION VI: WITNESSES TO SIGNATURE

23A. SIGNATURE OF WITNESS <i>(If claimant signed above using an "X")</i>	23B. PRINTED NAME AND ADDRESS OF WITNESS
24A. SIGNATURE OF WITNESS <i>(If claimant signed above using an "X")</i>	24B. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

**FULLY DEVELOPED CLAIM CERTIFICATION
(COMPENSATION)**

Name _____

Date _____

Claim Number _____

Social Security Number _____

Your signature on this response will not affect:

- Whether or not you are entitled to VA benefits;
- The amount of benefits to which you may be entitled;
- The assistance VA will provide you in obtaining evidence to support your claim; or
- The date any benefits will begin if your claim is granted.

I have enclosed all the information or evidence that will support my claim to include identifying records from Federal treating facilities, or I have no information or evidence to give VA to support my claim. Please decide my claim as soon as possible.

Claimant/Representative's Signature

Date



FULLY DEVELOPED CLAIM NOTICE

(Notice to Claimants of Information and Evidence Necessary to Substantiate a Claim for
VA Non-Service Connected Live Pension)

Thank you for participating in the Department of Veterans Affairs (VA) Fully Developed Claim Program. VA established the Fully Developed Claim Program to expeditiously process claims certified by the claimant or his/her representative as meeting the Fully Developed Claim criteria.

Fully Developed Claim Criteria:

1. For purposes of this notice, your claim must be a rating-related claim for live pension submitted on VA Form 21-527EZ, Fully Developed Claim (Pension).
2. You must submit, with your claim, the Fully Developed Claim Certification signed and dated by you or your authorized representative.
3. You must submit with the Fully Developed Claim Certification:
 - All necessary income and net-worth information.
 - All, if any, relevant, private medical treatment records, and an identification of any treatment records from a Federal treatment facility such as a VA medical center.
 - For Special Monthly Pension claims, a completed VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance, or if claiming Special Monthly Pension based on nursing home attendance, a VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance.
 - If claiming dependents, a completed VA Form 21-686c, Declaration of Status of Dependents.
4. You must report for any VA medical examinations VA determines necessary to decide your claim.

Note: VA forms are available at www.va.gov/vaforms.

This notice is applicable to your Fully Developed Claim for non-service connected live pension. Upon receipt of the Fully Developed Claim Certification, we will expedite your claim under the Fully Developed Claim Program. If it is determined that your claim does not meet the Fully Developed Claim criteria we will process your claim through our standard claim process.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

To support your claim for nonservice-connected pension, the evidence must show:

1. You met certain minimum requirements regarding active military service during a period of war. Generally, those requirements involve:
 - 90 days of consecutive service, at least one day of which was during a period of war; **OR**
 - 90 days of combined service during at least one period of war;

(Note: If your service began after September 7, 1980, additional length-of-service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligation)

- **OR** any length of active military service with a discharge due to a service-connected disability.
2. You are age 65 or older or are permanently and totally disabled. You are considered permanently and totally disabled if medical evidence shows you are:
 - A patient in a nursing home for long-term care; **OR**
 - Receiving Social Security disability benefits; **OR**
 - Unemployable due to a disability reasonably certain to continue throughout your lifetime; **OR**
 - Suffering from a disability that is reasonably certain to continue throughout your lifetime that would make it impossible for an average person to follow a substantially gainful occupation; **OR**
 - Suffering from a disease or disorder that VA determines causes persons who have that disease or disorder to be permanently and totally disabled.
 3. Your net worth and income do not exceed certain requirements.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM (*Continued*)

To support a claim for increased disability pension benefits based on the need for **aid and attendance**, the evidence must show:

- You have corrected vision of 5/200 or less in both eyes; **OR**
- You have contraction of the concentric visual field to 5 degrees or less; **OR**
- You are a patient in a nursing home due to mental or physical incapacity; **OR**
- You require the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment; **OR**
- You are bedridden, in that your disability requires that you remain in bed apart from any prescribed course of convalescence or treatment.

To support your claim for increased disability pension benefits based on being **housebound**, the evidence must show:

- You have a single permanent disability evaluated as 100 percent disabling; **AND** another disability, or disabilities, evaluated as 60 percent or more disabling; **OR**
- You have a single permanent disability evaluated as 100 percent disabling; **AND** due to such disability, you are permanently and substantially confined to your immediate premises; **OR**
- You were granted pension based on being 65 or older **AND** have a disability evaluated as at least 60 percent disabling.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant your claim, the beginning date of your entitlement will generally be based on when we received your claim.

Higher levels of nonservice-connected pension may be assigned for disabilities that affect your ability to perform certain activities of daily living or the ability to leave your home. Higher levels of pension may be effective from the date the medical evidence first shows entitlement.

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

Fully Developed Claim Process

VA will provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim. For this program, VA will only obtain Federal treatment records when you identify them. You must obtain all other records and provide them to VA.

If it is determined that other records exist, and VA needs the records to decide your claim, then your claim will not be processed as a Fully Developed Claim. Your claim will be processed in our standard claim process.

Standard Claim Process

VA is responsible for getting relevant records from any Federal agency that you adequately identify and authorize VA to obtain. These may include records from the military, VA medical centers (including private facilities where VA authorized treatment), or the Social Security Administration. VA will provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim.

VA will make every reasonable effort to obtain relevant records not held by a Federal agency that you adequately identify and authorize VA to obtain. These may include records from State or local governments, any privately held evidence and information you tell us about (such as private doctor or hospital records), or current or former employers.

WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable VA to obtain all relevant evidence not in your possession

Fully Developed Claim Process

If you provide VA information sufficient to enable VA to obtain relevant Federal treatment records and you give VA all other records relevant to your claim, the claim may be decided under the Fully Developed Claim Process. This means that, if you are aware of relevant records that are not in your possession, you should obtain them and provide them to VA in order to participate in the Fully Developed Claim Process.

Standard Claim Process

If you know of evidence not in your possession and want VA to try to get it for you, you must give VA enough information about the evidence so that we can request it from the person or agency that has it. If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. *It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.*

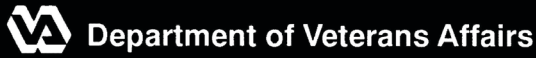
WHEN YOU SHOULD SEND WHAT WE NEED

Fully Developed Claim Process

Send the information and evidence with the Fully Developed Claim Certification. If we decide your claim before one year from the date we receive this claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support your claim.

Standard Claim Process

We strongly encourage you to send any information or evidence as soon as you can. If we do not hear from you, we may make a decision on your claim after 30 days. However, you have up to one year from the date we receive this claim to submit the information and evidence necessary to support your claim. If we decide your claim before one year from the date we receive this claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support your claim.



VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

**FULLY DEVELOPED CLAIM
(PENSION)**

IMPORTANT: Please read the Privacy Act and Respondent Burden on the back before completing the form. This claim must be submitted along with the attached, "Express Claim Certification."

SECTION I: TO BE COMPLETED BY VETERAN

1. VETERAN'S NAME (Last, first, middle)		2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	5. HAVE YOU EVER FILED A CLAIM WITH VA? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," provide your file number in Item 6)		6. VA FILE NUMBER
7A. CURRENT ADDRESS Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country		7B. TELEPHONE NUMBERS (Include Area Code) Daytime _____ Evening _____ Cell phone _____	
8A. PREFERRED E-MAIL ADDRESS (If applicable)		8B. ALTERNATE E-MAIL ADDRESS (If applicable)	
9. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING AND DATE DISABILITY(IES) BEGAN			
A. DISABILITY(IES)		B. DATE BEGAN	
10. LIST VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES			
A. NAME AND LOCATION OF VA MEDICAL CENTER		B. DATE(S) OF TREATMENT	

SECTION II: SERVICE INFORMATION

11A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES (If "Yes," go to Item 11B) <input type="checkbox"/> NO (If "No," go to Item 12A)		11B. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER	
12A. I ENTERED MY MOST RECENT PERIOD OF ACTIVE SERVICE ON	12B. BRANCH OF SERVICE		12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY
12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input type="checkbox"/> YES <input type="checkbox"/> NO	12E. PLACE OF SEPARATION		
13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. (National Guard)? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," provide date of activation in Item 13B)		13B. DATE OF ACTIVATION	
14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT?		14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? (Include Area Code)	
15A. DO YOU HAVE ADDITIONAL PERIODS OF ACTIVE SERVICE? <input type="checkbox"/> YES (If "Yes," go to Item 15B) <input type="checkbox"/> NO (If "No," go to Item 16A)	15B. I PREVIOUSLY ENTERED ACTIVE SERVICE ON		
16A. DID YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRED PAY? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 16B and 16C)	16B. LIST AMOUNT (If known) \$	16C. LIST TYPE (If known)	

SECTION III: WORK HISTORY

IN THE TABLE BELOW, TELL US ABOUT ALL OF YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR ONE YEAR BEFORE YOU BECAME DISABLED TO THE PRESENT.

17A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	17B. WHAT WAS YOUR JOB TITLE?	17C. WHEN DID YOUR WORK BEGIN?	17D. WHEN DID YOUR WORK END?	17E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	17F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
					\$
					\$

SECTION III: INCOME VERIFICATION

18A. MONTHLY INCOME (GROSS MONTHLY AMOUNTS (If no income was received from a particular source, write "0" or "none." DO NOT LEAVE BLANK))

SOURCE	VETERAN	SPOUSE
SOCIAL SECURITY	\$	\$
U.S. CIVIL SERVICE		
U.S. RAILROAD RETIREMENT		
BLACK LUNG BENEFITS		
MILITARY RETIREMENT		
OTHER (Show source below)		

18B. ANNUAL INCOME (If no income was received from a particular source, write "0" or "none." DO NOT LEAVE ANY ITEMS BLANK)

NOTE: Report last calendar year (January through December) income in the left-hand column and current year income in the right-hand column.

SOURCE	VETERAN		SPOUSE	
GROSS WAGES FROM ALL EMPLOYMENT	\$		\$	
TOTAL INTEREST AND DIVIDENDS				
ALL OTHER (Show source below)				
ALL OTHER (Show source below)				

18C. NET WORTH (If no income was received from a particular source, write "0" or "none." DO NOT LEAVE ANY ITEMS BLANK)

SOURCE	VETERAN	SPOUSE
CASH/NON-INTEREST-BEARING BANK ACCOUNTS	\$	\$
INTEREST-BEARING BANK ACCOUNTS		
IRA'S, KEOGH PLANS, ETC.		
STOCKS, BONDS, MUTUAL FUNDS, ETC.		
REAL PROPERTY (Not your home)		
ALL OTHER PROPERTY		

SECTION V: MEDICAL, LEGAL OR OTHER UNREIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. If more space is needed continue on page 6 or attach a separate sheet.

19A. Amount paid by you	19B. Date paid	19C. Purpose (Doctor's fees, hospital charges, attorney fees, etc.)	19D. Paid to (Name of doctor, hospital, pharmacy, etc.)	19E. Disability or relationship of person for whom expenses paid

SECTION V: MEDICAL, LEGAL OR OTHER UNREIMBURSED EXPENSES (Continued)

20A. Amount paid by you	20B. Date paid	20C. Purpose (<i>Doctor's fees, hospital charges, attorney fees, etc.</i>)	20D. Paid to (<i>Name of doctor, hospital, pharmacy, etc.</i>)	20E. Disability or relationship of person for whom expenses paid

SECTION VI: DIRECT DEPOSIT INFORMATION

Generally, all Federal payments are required to be made by electronic funds transfer (EFT), also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 21, 22 and 23 to enroll in Direct Deposit. If you do not have a bank account, we will give you a waiver from Direct Deposit, just check the box below in Item 21. The Treasury Department is working to make bank accounts available in such situations. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause a hardship if you enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street, Suite B, Muskogee, OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

21. ACCOUNT NUMBER (*Please check the appropriate box and provide the account number, if applicable*)

CHECKING _____

SAVINGS _____

I CERTIFY THAT I **DO NOT** HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

22. NAME OF FINANCIAL INSTITUTION (*Please provide the name of the bank where you want your direct deposit*)

23. ROUTING OR TRANSIT NUMBER (*The first nine numbers located at the bottom left of your check*)

SECTION VII: CERTIFICATIONS AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

24A. YOUR SIGNATURE (*Do NOT print*)

24B. DATE SIGNED

SECTION VIII: WITNESSES TO SIGNATURE

25A. SIGNATURE OF WITNESS (*If claimant signed above using an "X"*)

25B. PRINTED NAME AND ADDRESS OF WITNESS

26A. SIGNATURE OF WITNESS (*If claimant signed above using an "X"*)

26B. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

**FULLY DEVELOPED CLAIM CERTIFICATION
(PENSION)**

Name _____

Date _____

Claim Number _____

Social Security Number _____

Your signature on this response will not affect:

- Whether or not you are entitled to VA benefits;
- The amount of benefits to which you may be entitled;
- The assistance VA will provide you in obtaining evidence to support your claim; or
- The date any benefits will begin if your claim is granted.

I have enclosed all the information or evidence that will support my claim to include identifying records from Federal treating facilities, or I have no information or evidence to give VA to support my claim. Please decide my claim as soon as possible.

Claimant/Representative's Signature

Date

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:



**APPLICATION FOR VA EDUCATION BENEFITS
(VA FORM 22-1990)**

Use this form to apply for educational assistance under the following benefit programs:

- Post- 9/11 GI Bill chapter 33 of title 38, U.S. Code
- Montgomery GI Bill (MGIB) chapter 30 of title 38, U.S. Code
- Montgomery GI Bill - Selected Reserve (MGIB-SR) chapter 1606 of title 10, U.S. Code
- Reserve Educational Assistance Program (REAP) chapter 1607 of title 10, U.S. Code
- Post-Vietnam Era Veterans' Educational Assistance Program (VEAP) chapter 32 of title 38, U.S. Code, or section 901 or section 903 of Public Law 96-342

**INFORMATION AND INSTRUCTIONS
FOR COMPLETING THE APPLICATION FOR VA EDUCATION BENEFITS**

Do not use this form to apply for Vocational Rehabilitation and Employment benefits (chapter 31 of title 38, U.S. Code), Dependents Educational Assistance benefits (chapter 35 of title 38, U.S. Code), Transfer of Entitlement, or National Call to Service (section 510 of title 10, U.S. Code). These benefits require different application forms that can be completed on-line and printed at www.va.gov/vaforms or can be obtained from the nearest VA regional office. They may also be available where you received this application.

INTERNET VERSION AVAILABLE - You may complete and submit this application on-line at www.gibill.va.gov. Click "Apply On Line" and select the "Education" option.

VA VOCATIONAL AND EDUCATIONAL COUNSELING HELP AVAILABLE - If you need help planning your individual educational and career goals, VA offers a wide range of counseling services to help you make these decisions. Services include educational and vocational guidance and such testing as necessary for you to develop a greater understanding of your skills, talents, and interests. For further information on VA counseling, call VA toll-free at 1-888-GI-BILL-1 (1-888-442-4551) or TDD at (800) 829-4833.

NOTE: The numbers on the instructions match the item numbers on the application. Items not mentioned are self-explanatory.

Part II

(This section provides an overview of the general eligibility requirements for various education programs. Additional requirements not listed on this form may be necessary.)

ITEM 9A. You may be eligible for benefits under the Post-9/11 GI Bill, also referred to as chapter 33, if you served at least 90 aggregate days on active duty (excluding entry level and skill training) after September 10, 2001. You may also qualify if you were discharged due to a service-connected disability after serving at least 30 continuous days on active duty after September 10, 2001.

ITEM 9B. You may be eligible for the Montgomery GI Bill, also referred to as MGIB or chapter 30, if you served on active duty and meet certain conditions. NOTE: You do not have to be on active duty to apply for benefits under this program. You must meet any one of the following conditions (there are additional requirements):

You first entered service on or after July 1, 1985, and you didn't decline this benefit at your initial entry into service

OR

You entered service (or agreed to delayed entry) before January 1, 1977, and you have educational assistance entitlement remaining under the Vietnam Era GI Bill (also known as "chapter 34")

OR

You were voluntarily separated under the Voluntary Separation Incentive (VSI) or Special Separation Benefit (SSB) programs and had your military pay reduced by \$1,200

OR

You were involuntarily separated from active duty after February 2, 1991,

OR

You were on active duty and a participant in the Post-Vietnam Era Veterans' Educational Assistance Program (VEAP) program on or before October 9, 1996, or you first entered the National Guard under title 32, U.S. Code, between July 1, 1985, and November 28, 1989, you elected chapter 30 benefits between October 9, 1996, and October 8, 1997, and you paid \$1,200

OR

You were on active duty and eligible for VEAP benefits on October 9, 1996, you elected chapter 30 benefits between November 1, 2000, and October 31, 2001, and you paid \$2,700.

ITEM 9C. You may be eligible for the Montgomery GI Bill - Selected Reserve Educational Assistance Program, also known as MGIB-SR or chapter 1606, if you are a member of the Selected Reserve and meet certain requirements, including a 6-year commitment. (The Departments of Defense and Homeland Security determine eligibility for this program.)

To expedite processing, attach a copy of your DD 2384, Selected Reserve Educational Assistance Program (GI BILL) Notice of Basic Eligibility. This form is also called a "NOBE." Your reserve unit should have issued this notice to you when you became eligible for the Montgomery GI Bill - Selected Reserve Educational Assistance Program. If you are unable to locate your copy, request a duplicate from your reserve unit.

ITEM 9D. You may be eligible for benefits under the Reserve Educational Assistance Program (REAP), also known as chapter 1607, if you are a member of the Ready Reserve and were called or ordered to active service to support a contingency operation for at least 90 consecutive days on or after September 11, 2001. (The Department of Defense and Homeland Security determine eligibility for this program.)

Attach a copy of any notice of eligibility to this program that you have received from your service component. Also, attach a copy of your orders showing you were called up to active service. If you do not have a copy of your orders, request a duplicate from your unit.

ITEM 9E. You may be eligible for benefits under the Post-Vietnam Era Veterans' Educational Assistance Program (VEAP), also known as Chapter 32, if your service began on or after January 1, 1977, and before July 1, 1985, and you contributed to a VEAP account. You may be eligible for benefits under the Post-Vietnam Era Non-Contributory Veterans' Educational Assistance Program, also known as "Non-Contributory VEAP" or Section 903", if your service began on or after November 30, 1980, and before October 1, 1981, and your branch of service paid contributions into your VEAP account.

ITEM 9F. If you are eligible for MGIB, MGIB-SR, OR REAP, you must elect to give up eligibility under the program for which you are eligible in order to receive benefits under the Post-9/11 GI Bill (chapter 33). If you are eligible for more than one of the programs listed (MGIB, MGIB-SR, and REAP), you are only required to give up one of the programs for which you are eligible in order to receive benefits under the Post-9/11 GI Bill. You may not receive more than a total of 48 months of benefits under two or more programs. If you elect chapter 33 in lieu of chapter 30, your months of entitlement under chapter 33 will be limited to the number of months of entitlement remaining under chapter 30 on the effective date of your election. However, if you completely exhaust your entitlement under chapter 30 before the effective date of your chapter 33 election, you may receive up to 12 additional months of benefits under chapter 33. If you wish to elect to receive benefits under the Post-9/11 GI Bill, check the box next to the program (only check one box) you are giving up.

NOTE: An election to give up benefits under an existing program and receive benefits under the Post-9/11 GI Bill is **IRREVOCABLE**. You should carefully consider your decision before completing this section. If you need more information to make a choice, you should visit our website at www.gibill.va.gov or call our toll-free customer service number at 1-888-GIBILL-1 (1-888-442-4551).

PART III

ITEM 10A. Self explanatory, except for the following items:

"Vocational Flight Training." You must already have a private pilot's license. If you are taking an Airline Transport Pilot course, you must have a valid first-class medical certificate on the date that you enter training. For all other flight courses, you must have a valid second-class medical certificate on the date that you enter training.

"National Test Reimbursement." You can be reimbursed for the cost of approved tests for admission to, or credit at, institutions of higher learning.

"Licensing or Certification Test Reimbursement." A licensing test is a test offered by a state, local, or federal agency that is required by law to practice an occupation. A certification test is a test designed to provide affirmation of an individual's qualifications in a specific occupation. Examples include EMT, CPA, MCSE, CCNP, etc.

"Tuition Assistance Top-Up" This benefit is payable only under MGIB and the Post-9/11 GI Bill programs. You can receive benefits to pay you for the difference between what the military pays with Tuition Assistance (TA) and the total costs of these courses.

PART VIII

QUESTIONS ARE ONLY FOR APPLICANTS WHOSE SERVICE BEGAN BEFORE JANUARY 1, 1977, (or delayed entry before January 2, 1978). If you are currently married or if you have children under age 18 (under age 23 if in school), you should complete and return VA Form 21-686c. If your children are in school, you should also complete and return VA Form 21-674 for each child. If your parent(s) are dependent on you for financial support, you should complete and return VA Form 21-509. These forms may require additional documentation. VA cannot pay any additional benefits for dependents without properly completed forms and documentation. You can find VA forms 21-686c, 21-674, and 21-509 on-line at www.va.gov/vaforms.

ADDITIONAL HELP

If you need more help in completing this application, call VA TOLL FREE at 1-888-GI-BILL-1 (1-888-442-4551). If you are hearing impaired, call us toll-free at 1-800-829-4833. You can also get education assistance after normal business hours at our education Internet site www.gibill.va.gov.

HOW TO FILE YOUR CLAIM

Be sure to do the following:

(A) If you have selected a school or training establishment:

Step 1: Mail the completed application to the VA Regional Processing Office for the region of that school's physical address. See next page for the addresses of these VA Regional Processing Offices.

Step 2: Tell the veterans certifying official at your school or training establishment that you have applied for VA education benefits. Ask him or her to send your enrollment information using VA Form 22-1999, Enrollment Certification, or its electronic version.

Step 3: Wait for VA to process your application and notify you of its decision concerning your eligibility for education benefits.

(B) If you haven't selected a school or training establishment:

Step 1: Mail the completed application to the VA Regional Processing Office for the region of your home address. See next page for the addresses of these VA Regional Processing Offices.

Step 2: Wait for VA to process your application and notify you of its decision concerning your eligibility for education benefits.

**Eastern Region:
VA Regional Office
P.O. Box 4616
Buffalo, NY 14240-4616**

Serves the following states:

CT	DE	DC	ME
MD	MA	NH	NJ
NY	OH	PA	RI
VT	VA	WV	Foreign Schools

**Central Region:
VA Regional Office
P.O. Box 66830
St. Louis, MO 63166-6830**

Serves the following states:

CO	IA	IL	IN
KS	KY	MI	MN
MO	MT	NE	ND
SD	TN	WI	WY

**Western Region:
VA Regional Office
P.O. Box 8888
Muskogee, OK 74402-8888**

Serves the following states:

AK	AL	AR	AZ
CA	HI	ID	LA
MS	NM	NV	OK
OR	TX	UT	WA
Philippines	Guam	APO/FPO AP	

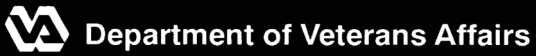
**Southern Region:
VA Regional Office
P.O. Box 10022
Decatur, GA 30031-7022**

Serves the following states:

FL	GA	NC	SC
PR	US Virgin Islands	APO/FPO AA	

Privacy Act Notice: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or title 38, Code of Federal Regulations, section 1.576 for routine uses (e.g., VA sends educational forms or letters with a veteran's identifying information to the veteran's school or training establishment to (1) assist the veteran in the completion of claims forms or (2) for the VA to obtain further information as may be necessary from the school for the VA to properly process the veteran's education claim or to monitor his or her progress during training) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain education benefits. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law enacted before January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the maximum benefits under the law. While you do not have to respond, VA cannot process your claim for education assistance unless the information is furnished as required by existing law (38 U.S.C. 3471). The responses you submit are considered confidential (38 U.S.C. 5701). Any information provided by applicants, recipients, and others may be subject to verification through computer matching programs with other agencies.

Respondent Burden: We need this information to determine your eligibility for education benefits (38 U.S.C. 3471). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB (Office of Management and Budget) control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at <http://www.reginfo.gov/public/do/PRAMain>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



APPLICATION FOR VA EDUCATION BENEFITS

(See attached Information and Instructions)

INTERNET VERSION AVAILABLE - You may complete and send your application over the Internet at: www.gibill.va.gov

PART I - APPLICANT INFORMATION

1. SOCIAL SECURITY NUMBER OF APPLICANT <input style="width: 100%;" type="text"/>	2. SEX OF APPLICANT <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3. APPLICANT'S DATE OF BIRTH Month Day Year <input style="width: 30px;" type="text"/> - <input style="width: 30px;" type="text"/> - <input style="width: 60px;" type="text"/>
---	--	---

4. NAME (First, Middle Initial, Last)

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

5. APPLICANT'S ADDRESS

Number and Street

Apt./Unit Number

City, State, ZIP Code

6A. APPLICANT'S TELEPHONE NUMBERS (Include Area Code)

Primary: Secondary:

6B. APPLICANT'S E-MAIL ADDRESS (If applicable)

7. DIRECT DEPOSIT (Attach a voided personal check or provide the following information. Direct Deposit is not available for VEAP)

Routing or Transit Number	Account Type	Account Number
<input style="width: 100%;" type="text"/>	Checking <input type="checkbox"/> Savings <input type="checkbox"/>	<input style="width: 100%;" type="text"/>

8. PLEASE PROVIDE THE NAME, ADDRESS, AND PHONE NUMBER OF SOMEONE WHO WILL ALWAYS KNOW WHERE YOU CAN BE REACHED

A. NAME	B. ADDRESS	C. PHONE NUMBER
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

PART II - EDUCATION BENEFIT BEING APPLIED FOR *See instructions for benefit eligibility criteria*

- 9A. Chapter 33 - Post-9/11 GI Bill (Complete 9F if you are eligible for chapter 30, chapter 1606, or chapter 1607)
- 9B. Chapter 30 - Montgomery GI Bill Educational Assistance Program (MGIB)
- 9C. Chapter 1606 - Montgomery GI Bill - Selected Reserve Educational Assistance Program (MGIB-SR)
- 9D. Chapter 1607 - Reserve Educational Assistance Program (REAP)
- 9E. Chapter 32 or Section 903 - Post-Vietnam Era Veterans' Educational Assistance Program (VEAP)

9F. By electing Chapter 33, I acknowledge that I understand the following:

- I may not receive more than a total of 48 months of benefits under two or more programs.
- If electing chapter 33 in lieu of chapter 30, my months of entitlement under chapter 33 will be limited to the number of months of entitlement remaining under chapter 30 on the effective date of my election. However, if I completely exhaust my entitlement under chapter 30 before the effective date of my chapter 33 election, I may receive up to 12 additional months of benefits under chapter 33.
- My election is **irrevocable** and may not be changed.

I elect to receive chapter 33 education benefits in lieu of the education benefit checked below, effective _____ (date)

I understand that my election is irrevocable and may not be changed. (Check only one)

- Chapter 30 - Montgomery GI Bill Educational Assistance Program (MGIB)
- Chapter 1606 - Montgomery GI Bill - Selected Reserve Educational Assistance Program (MGIB-SR)
- Chapter 1607 - Reserve Educational Assistance Program (REAP)

PART III - TYPE AND PROGRAM OF EDUCATION OR TRAINING

10A. TYPE OF EDUCATION OR TRAINING (See instructions for additional information)

<input type="checkbox"/> COLLEGE OR OTHER SCHOOL (Including on-line courses)	<input type="checkbox"/> APPRENTICESHIP OR ON-THE-JOB
<input type="checkbox"/> VOCATIONAL FLIGHT TRAINING	<input type="checkbox"/> CORRESPONDENCE
<input type="checkbox"/> NATIONAL TEST REIMBURSEMENT (SAT, CLEP, ETC.)	<input type="checkbox"/> TUITION ASSISTANCE TOP-UP (Chapter 30 & 33 only)
<input type="checkbox"/> LICENSING OR CERTIFICATION TEST REIMBURSEMENT (MCSE, CCNA, EMT, NCLEX, ETC.)	

VA DATE STAMP
(Do Not Write In This Space)

10B. PROVIDE THE FULL NAME AND ADDRESS OF THE SCHOOL, IF KNOWN *(Skip this item if you are only applying for National Test Reimbursement, Licensing and Certification Test Reimbursement, or Tuition Assistance Top-Up)*

10C. PLEASE SPECIFY YOUR EDUCATIONAL OR CAREER OBJECTIVE, IF KNOWN *(e.g. Bachelor of Arts in Accounting, welding certificate, police officer, etc.)*

PART IV - SERVICE INFORMATION

NOTE: It will help VA process your claim if you send a copy of the following:

- DD Form 214 (Member 4) for all periods of active duty service (excluding active duty for training)
- DD Form 2384, Notice of Basic Eligibility (NOBE) if applying for Chapter 1606
- Copies of orders if activated from the guard/reserves

11. ARE YOU NOW ON ACTIVE DUTY? *(Do not check "Yes" if you are currently on drilling status in the Selected Reserve, or if you are on active duty for training)*

YES NO

12. ARE YOU NOW ON TERMINAL LEAVE JUST BEFORE DISCHARGE?

YES NO *(Please provide a copy of your DD Form 214 (Member 4) when issued)*

13. PLEASE COMPLETE THE FOLLOWING FOR EACH PERIOD OF MILITARY SERVICE

A. DATE ENTERED	B. DATE SEPARATED	C. SERVICE COMPONENT <i>(USN, USAF, USAR, ARNG, ETC.)</i>	D. SERVICE STATUS <i>(Active duty, drilling reservist, IRR, etc.)</i>	E. WERE YOU INVOLUNTARILY CALLED TO ACTIVE DUTY FOR THIS PERIOD?
9/26/2000	9/24/2004	USMC (EXAMPLE)	ACTIVE DUTY	NO
1/18/2005	8/14/2007	USMCR	DRILLING	N/A
8/15/2007	Present	USMC	ACTIVE DUTY	YES

PART V - EDUCATION AND EMPLOYMENT INFORMATION

14A. DID YOU RECEIVE A HIGH SCHOOL DIPLOMA OR HIGH SCHOOL EQUIVALENCY CERTIFICATE? *(If "Yes" provide date)*

YES DATE: _____ NO

14B. DO YOU HOLD ANY FAA FLIGHT CERTIFICATES? *(If "Yes," specify each certificate in Part IX, Remarks)*

YES NO

14C. EDUCATION AFTER HIGH SCHOOL *(Including apprenticeship, on-the-job training, and flight training)*

NAME AND LOCATION OF COLLEGE OR OTHER TRAINING PROVIDER	DATES OF TRAINING		NUMBER AND TYPE OF HOURS <i>(Semester, Quarter, or Clock)</i>	DEGREE, DIPLOMA, OR CERTIFICATE RECEIVED	MAJOR FIELD OR COURSE OF STUDY
	FROM	TO			

14D. EMPLOYMENT (Only complete if you held a license or journeyman rating to practice a profession)

EMPLOYMENT	PRINCIPAL OCCUPATION	NUMBERS OF MONTHS WORKED	LICENSE OR RATING
BEFORE MILITARY SERVICE			
AFTER MILITARY SERVICE			

PART VI - ENTITLEMENT TO AND USAGE OF ADDITIONAL TYPES OF ASSISTANCE

<p>15. DID YOU MAKE ADDITIONAL CONTRIBUTIONS (UP TO \$600.00) TO INCREASE THE AMOUNT OF YOUR MONTHLY BENEFITS? IF "YES," IT WILL HELP VA PROCESS YOUR CLAIM IF YOU SUBMIT ANY EVIDENCE YOU HAVE TO SUPPORT YOUR CLAIM (e.g., cash collection voucher, leave and earnings statement(s), receipt voucher, etc.)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>16. DO YOU QUALIFY FOR A KICKER (sometimes called a "College Fund") BASED ON YOUR MILITARY SERVICE? (Kickers are additional amounts contributed by DOD to an education fund). If you qualify for a kicker, it will help VA process your claim if you submit a copy of the kicker contract. Reserve kicker contracts must include the amount and effective date.</p>	<p>ACTIVE DUTY KICKER <input type="checkbox"/> YES <input type="checkbox"/> NO RESERVE KICKER <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>17. IF YOU GRADUATED FROM A MILITARY SERVICE ACADEMY, SPECIFY THE YEAR YOU GRADUATED AND RECEIVED YOUR COMMISSION.</p>	<p>Graduation Year</p>
<p>18. WERE YOU COMMISSIONED AS THE RESULT OF A SENIOR ROTC (Reserve Officers Training Corps) SCHOLARSHIP? If you received your commission through a non-scholarship program, check "No." If "Yes," provide the date of your commission and the amount of your scholarship for each school year you were in the Senior ROTC program. Don't report your monthly subsistence allowance (stipend).</p> <p>Scholarship Amounts:</p> <p>Year: _____ Amount: _____</p> <p>Year: _____ Amount: _____</p> <p>Year: _____ Amount: _____</p> <p>Year: _____ Amount: _____</p> <p>Year: _____ Amount: _____</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Date of Commission</p> <p>_____</p>
<p>19. ARE YOU CURRENTLY PARTICIPATING IN A SENIOR ROTC SCHOLARSHIP PROGRAM THAT PAYS FOR YOUR TUITION, FEES, BOOKS AND SUPPLIES UNDER SECTION 2107 OF TITLE 10, U.S. CODE?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>20. IF YOU HAD A PERIOD OF ACTIVE DUTY THAT THE DEPARTMENT OF DEFENSE COUNTS FOR PURPOSES OF REPAYING AN EDUCATION LOAN, CHECK "YES". SHOW THE PERIOD OF ACTIVE DUTY THAT THE MILITARY CONSIDERS AS BEING USED FOR THE PURPOSES OF REPAYING THIS EDUCATION LOAN IN PART IX "REMARKS".</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>21. FOR ACTIVE DUTY CLAIMANTS ONLY: ARE YOU RECEIVING, OR DO YOU ANTICIPATE RECEIVING, ANY MONEY (INCLUDING BUT NOT LIMITED TO FEDERAL TUITION ASSISTANCE) FROM THE ARMED FORCES OR PUBLIC HEALTH SERVICE FOR THE COURSE FOR WHICH YOU HAVE APPLIED TO THE VA FOR EDUCATION BENEFITS? IF YOU RECEIVE SUCH BENEFITS DURING ANY PART OF YOUR TRAINING, CHECK "YES." NOTE: IF YOU ARE ONLY APPLYING FOR TUITION ASSISTANCE TOP-UP, CHECK NO IN THIS ITEM.</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>22. FOR CIVILIAN EMPLOYEES OF THE U.S. GOVERNMENT ONLY: ARE YOU RECEIVING, OR DO YOU ANTICIPATE RECEIVING, ANY MONEY (INCLUDING, BUT NOT LIMITED TO, THE GOVERNMENT EMPLOYEES TRAINING ACT) FROM YOUR AGENCY FOR THE SAME PERIOD FOR WHICH YOU HAVE APPLIED TO THE VA FOR EDUCATION BENEFITS? IF YOU WILL RECEIVE SUCH BENEFITS DURING ANY PART OF YOUR TRAINING, CHECK "YES."</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

PART VII - INFORMATION ON VA EDUCATION BENEFITS

NOTE: The most current information on VA education benefits is available online at www.gibill.va.gov

If you would like to receive a printed pamphlet check here.

PART VIII - MARITAL AND DEPENDENCY STATUS

NOTE : Only complete this section if you have military service before January 1, 1977 (or delayed entry before January 2, 1978). See instructions.

23. ARE YOU MARRIED?

YES NO

24. DO YOU HAVE ANY CHILDREN WHO ARE UNDER AGE 18, **OR** OVER 18 BUT UNDER AGE 23, NOT MARRIED AND ATTENDING SCHOOL, **OR** OF ANY AGE PERMANENTLY HELPLESS FOR MENTAL OR PHYSICAL REASONS?

YES NO

25. DO YOU HAVE A PARENT WHO IS DEPENDENT UPON YOU FOR FINANCIAL SUPPORT?

YES NO

PART IX - REMARKS

(If more space is needed, please attach a separate sheet of paper. Be sure to include your name and social security number on each sheet)

APPLICATION SUBMISSION REMINDERS

Did you remember to

- Write your social security number on each page?
- Write your complete mailing address?
Attach all supporting documents (*e.g. voided check, orders, DD214, kicker contract, NOBE, cash collection voucher, etc.*)?

IF SO, PLEASE SIGN AND DATE THE APPLICATION BELOW

PART X - CERTIFICATION AND SIGNATURE OF APPLICANT

I CERTIFY THAT all statements in my application are true and correct to the best of my knowledge and belief. If on active duty, I also certify that I have consulted with an Education Service Officer (ESO) regarding my education program.

PENALTY - Willful false statements as to a material fact in a claim for education benefits is a punishable offense and may result in the forfeiture of these or other benefits and in criminal penalties.

26A. SIGNATURE OF APPLICANT (*DO NOT PRINT*)

26B. DATE SIGNED

19. NAME AND ADDRESS OF SCHOOL OR TRAINING FACILITY (Number and street or rural route, city or P.O., State and ZIP Code)

20. SPECIFY YOUR EDUCATION OR CAREER OBJECTIVE, IF KNOWN (e.g., Bachelor of Arts in Accounting, Welding Certificate, Police Officer)

21. DATE YOU WILL BEGIN SCHOOL OR TRAINING

MONTH DAY YEAR

**PART IV - DEA APPLICANT AND ELECTION INFORMATION
(Fry Scholarship Applicants, Skip to Part V)**

SECTION I - APPLICANT INFORMATION

22. IF YOU ARE THE SPOUSE OF A DISABLED VETERAN, IS A DIVORCE OR ANNULMENT PENDING?
 YES NO

23. ARE YOU A HANDICAPPED CHILD (14 YEARS OR OLDER), SPOUSE, OR SURVIVING SPOUSE SEEKING SPECIAL RESTORATIVE TRAINING?
 YES NO

24. ARE YOU A HANDICAPPED CHILD, SPOUSE, OR SURVIVING SPOUSE SEEKING SPECIALIZED VOCATIONAL TRAINING?
 YES NO

25. IF YOU ARE THE SURVIVING SPOUSE OF A DECEASED VETERAN, HAVE YOU REMARRIED SINCE HIS OR HER DEATH?
 YES NO (If "Yes," please provide date of remarriage) MONTH DAY YEAR

SECTION II - ELECTION (CHILD APPLICANTS ONLY)

IMPORTANT: You may not receive payments of Dependency and Indemnity Compensation (DIC) or Pension and you may not be claimed as a dependent in a compensation claim while receiving Survivors' and Dependents' Educational Assistance (DEA). CAREFULLY READ THE INSTRUCTIONS BEFORE COMPLETING THIS ELECTION BLOCK. YOU ARE STRONGLY ENCOURAGED TO DISCUSS YOUR ELECTION WITH A VA COUNSELOR.

26. I CERTIFY that I understand the effects of an election to receive DEA benefits and I elect to receive such benefits on the following date:

MONTH DAY YEAR

PART V - APPLICATION HISTORY

27. PRIOR TO THIS APPLICATION, HAVE YOU EVER APPLIED FOR OR RECEIVED ANY OF THE FOLLOWING VA BENEFITS? (Check all appropriate boxes)

A. DISABILITY COMPENSATION OR PENSION

B. DEPENDENTS' INDEMNITY COMPENSATION (DIC)

C. VOCATIONAL REHABILITATION BENEFITS (Chapter 31)

D. VETERANS EDUCATION ASSISTANCE BASED ON YOUR OWN SERVICE SPECIFY BENEFIT(S): _____

E. VETERANS EDUCATION ASSISTANCE BASED ON SOMEONE ELSE'S SERVICE SPECIFY BENEFIT(S) BY CHECKING APPLICABLE BOX BELOW AND COMPLETE ITEMS 28 AND 29

CHAPTER 35 - SURVIVORS' AND DEPENDENTS' EDUCATIONAL ASSISTANCE PROGRAM (DEA)

CHAPTER 33 - POST-9/11 GI BILL MARINE GUNNERY SERGEANT DAVID FRY SCHOLARSHIP

TRANSFERRED ENTITLEMENT

F. NONE

G. OTHER (Specify benefit(s)) _____

IMPORTANT: Complete Items 28 and 29 only if you checked block "E" in Item 27

28. NAME OF INDIVIDUAL ON WHOSE ACCOUNT YOU PREVIOUSLY CLAIMED BENEFITS (First, Middle, Last)

29. SOCIAL SECURITY NUMBER OF INDIVIDUAL ON WHOSE ACCOUNT YOU PREVIOUSLY CLAIMED BENEFITS

PART VI - APPLICANT'S MILITARY SERVICE INFORMATION

(Note: Chapter 35 benefits are not payable while an eligible person is on active duty)

30. HAVE YOU EVER SERVED ON ACTIVE DUTY IN THE ARMED FORCES? (If "No," skip to Part VII)
 YES NO

31. INFORMATION ABOUT YOUR PERIOD(S) OF ACTIVE DUTY

A. DATE ENTERED ACTIVE DUTY	B. DATE SEPARATED FROM ACTIVE DUTY	C. BRANCH OF SERVICE OR RESERVE OR GUARD COMPONENT	D. CHARACTER OF DISCHARGE

PART VII - EDUCATION, TRAINING, AND EMPLOYMENT

SECTION I - EDUCATION & TRAINING

32. CHECK THE APPROPRIATE BOX AND ENTER THE DATE IN ITEM 33

<input type="checkbox"/> GRADUATED FROM HIGH SCHOOL	<input type="checkbox"/> DISCONTINUED HIGH SCHOOL
<input type="checkbox"/> EXPECT TO GRADUATE FROM HIGH SCHOOL	<input type="checkbox"/> AWARDED GED
<input type="checkbox"/> NEVER ATTENDED HIGH SCHOOL	

33. DATE

34A. TYPE OF SCHOOL	34B. NAME AND LOCATION OF SCHOOL <i>(City and State)</i>	34C. DATES OF TRAINING		34D. NUMBER OF SEMESTER, QUARTER, OR CLOCK HOURS COMPLETED	34E. DEGREE, DIPLOMA, OR CERTIFICATE RECEIVED	34F. MAJOR FIELD OR COURSE OF STUDY
		FROM	TO			
HIGH SCHOOL						
COLLEGE						
VOCATIONAL OR TRADE						
OTHER <i>(Specify)</i>						

SECTION II - EMPLOYMENT

35. CURRENT AND PAST EMPLOYMENT

A. EMPLOYER	B. JOB TITLE	C. NUMBER OF MONTHS EMPLOYED	D. LICENSE OR RATING

NOTE: Complete Item 36 **only** if you are a civilian employee of the U.S. Government

36A. DO YOU EXPECT TO RECEIVE FUNDS FROM YOUR AGENCY OR DEPARTMENT FOR THE SAME COURSES FOR WHICH YOU EXPECT TO RECEIVE VA EDUCATIONAL ASSISTANCE? <i>(If "Yes," complete Item 36B)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	36B. SOURCE OF EDUCATIONAL ASSISTANCE FROM GOVERNMENT EMPLOYMENT
---	--

PART VIII - REMARKS, REMINDERS AND VA EDUCATION BENEFITS PAMPHLET

SECTION I - REMARKS

37. REMARKS *(If more space is needed, please attach a separate sheet of paper. Be sure to include name and social security number on each sheet)*

SECTION II - REMINDERS

DID YOU REMEMBER TO:

- WRITE YOUR SOCIAL SECURITY NUMBER ON EACH PAGE
- WRITE YOUR COMPLETE MAILING ADDRESS
- ATTACH SUPPORTING DOCUMENTS *(e.g., birth certificate, marriage license, DD214, etc.)*

SECTION III - VA EDUCATION BENEFITS PAMPHLET

38. THE MOST CURRENT INFORMATION ON VA EDUCATION BENEFITS IS AVAILABLE ONLINE AT www.gibill.va.gov IF YOU WOULD LIKE A COPY OF THE VA EDUCATION BENEFITS PAMPHLET PLEASE CHECK THE BOX.

PART IX - CERTIFICATION AND SIGNATURE OF APPLICANT

I CERTIFY THAT all statements in my application are true and correct to the best of my knowledge and belief.

39A. SIGNATURE OF APPLICANT <i>(DO NOT PRINT)</i> SIGN HERE IN INK	39B. DATE SIGNED
---	------------------

PENALTY: Willfully false statements as to a material fact in a claim for education benefits is a punishable offense and may result in the forfeiture of these or other benefits and in criminal penalties.

(Please detach at perforation and retain this information for future reference)

**INFORMATION AND INSTRUCTIONS FOR COMPLETING THE
DEPENDENTS' APPLICATION FOR VA EDUCATION BENEFITS
(VA FORM 22-5490)**

Use this form to apply for educational assistance under the following benefit programs:

- Survivors' and Dependents' Educational Assistance Program (DEA) (chapter 35 of title 38, U.S. Code)
- Post-9/11 GI Bill Marine Gunnery Sergeant John David Fry Scholarship (Fry Scholarship) (chapter 33 of title 38, U.S. Code)

Do not use this form to apply for Veterans' education assistance based on your own service (chapters 30, 32, 33, 1606, or 1607) or vocational rehabilitation benefits (chapter 31). To apply for veterans' education assistance based on your own service, use VA Form 22-1990. To apply for vocational rehabilitation benefits, use VA Form 28-1900.

INTERNET VERSION AVAILABLE - You may complete and submit this application on-line at www.gibill.va.gov. Click on "GI Bill: Apply for Benefits."

VA VOCATIONAL AND EDUCATIONAL COUNSELING HELP AVAILABLE - VA offers a wide range of services to assist you in planning your educational and/or career goals. Services include educational and vocational guidance and testing to develop a greater understanding of your skills, talents, and interests. For more information on VA counseling, call VA toll-free at 1-888-GIBILL-1 (1-888-442-4551) or TDD at 1-800-829-4833.

NOTE: The number on the instructions match the item numbers on this application. Items not mentioned are self-explanatory.

ITEM 17. You will not be eligible to receive benefits for any period for which you or the qualifying individual on whose account you are claiming benefits has an outstanding felony warrant. Any benefits paid to you for such period will result in an overpayment and be subject to collection.

ITEM 18.

18A. Select the benefit for which you are applying.

To qualify for Survivors' and Dependents' Educational Assistance (DEA) you must be either -

- (1) The spouse or child of a veteran who is permanently and totally disabled as a result of a service-connected disability.
- (2) The spouse or child of an individual on active duty who has been listed as missing in action, captured in line of duty by hostile force, forcibly detained or interned in line of duty by hostile force, or forcibly detained or interned in line of duty by foreign government or power for more than 90 days.
- (3) The surviving spouse or child of a veteran who died of a service-connected disability or who dies while a service-connected disability was rated permanent and total in nature.
- (4) The spouse or child of an individual on active duty for which the evidence shows that the individual is hospitalized for receiving outpatient medical care services or treatment; has a total disability permanent in nature incurred or aggravated in the line of duty in the active military, naval, or air service; and the serviceperson is likely to be discharged or released from such service for such disability.

Eligibility for DEA will be terminated in the event that VA determines that the individual on whose account benefits are claimed is no longer totally disabled or VA is notified that the individual is no longer listed as captured, missing in action, or forcibly detained.

18B. To qualify for the Fry Scholarship, you must be the child of an individual who after September 10, 2001, died in the line of duty while serving on active duty as a member of the Armed Forces.

18A. & 18B. Types of education or training programs are self-explanatory, except for the following -

"Licensing or Certification Test." A licensing test is a test offered by a state, local, or federal agency that is required by law to practice an occupation. A certification test is a test designed to provide affirmation of an individual's qualifications in a specific occupation.

"National Admission Exam or National Exam for Credit." Individuals eligible to receive benefits under the Survivors' and Dependents' Educational Assistance program may be reimbursed for the cost of approved tests for admission to or credit at institutions of higher learning.

"Correspondence." Only spouses and surviving spouses eligible for the Survivors' and Dependents' Educational Assistance program may receive benefits for correspondence training. Payments for correspondence courses are made quarterly after VA receives a certification showing the number of lessons completed. For more information on correspondence courses, please visit our website at www.gibill.va.gov.

INFORMATION AND INSTRUCTIONS (Continued)

ITEMS 23 and 24. Any individual eligible under the Survivors' and Dependents' Educational Assistance program may receive Special Restorative Training or Specialized Vocational Training if a VA counselor determines that a specialized program is needed to overcome the effects of a physical or mental handicap. To be eligible for receipt of specialized training, the disability must prevent you from pursuing an educational program. Examples of Special Restorative Training include speech and voice correction, language retraining, lip reading, and Braille reading and writing. Specialized Vocational Training consists of specialized courses leading to a suitable vocational objective.

ITEM 26. Your election to receive Survivors' and Dependents' Educational Assistance (DEA) is final and cannot be changed. This means that payments of compensation, pension, and Dependents' Indemnity Compensation (DIC) will be terminated upon issuance of a DEA benefit payment. If you are planning to pursue a program of education for more than 45 months, you should consider deferring receipt of DEA benefits. We strongly recommend that you discuss your education or training plans with a VA counselor before making a decision. If you decide to elect benefits under DEA, indicate the date from which you wish your DEA payments to begin.

HOW TO FILE YOUR CLAIM

Be sure to do the following:

(A) If you have selected a school or training establishment:

Step 1: Mail the completed application to the VA Regional Processing Office for the region of that school's physical address. See reverse for the addresses of these VA Regional Processing Offices.

Step 2: Tell the veterans certifying official at your school or training establishment that you have applied for VA education benefits. Ask him or her to submit your enrollment information using VA Form 22-1999, Enrollment Certification, or its electronic version.

Step 3: Wait for VA to process your application and notify you of its decision concerning your eligibility for education benefits.

(B) If you have not selected a school or training establishment:

Step 1: Mail the completed application to the VA Regional Processing Office for the region of your home address. Check next page for the post office box address for these offices.

Step 2: Wait for VA to process your application and notify you of its decision concerning your eligibility for education benefits.

ADDITIONAL HELP COMPLETING APPLICATION

If you need additional help completing this application or you want information about our work-study program, call VA toll-free at 1-888-GIBILL-1 (1-888-442-4551). If you are hearing impaired, call us toll-free at 1-800-829-4833. You can also get more information about education assistance from our education Internet site at www.gibill.va.gov.

Eastern Region: VA Regional Office P. O. Box 4616 Buffalo, NY 14240-4616			
SERVES THE FOLLOWING STATES			
CT	DE	DC	ME
MD	MA	NH	NJ
NY	OH	PA	RI
VT	VA	WV	Foreign Schools

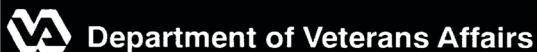
Central Region: VA Regional Office P. O. Box 66830 St. Louis, MO 63166-6830			
SERVES THE FOLLOWING STATES			
CO	IA	IL	IN
KS	KY	MI	MN
MO	MT	NE	ND
SD	TN	WY	WI

Western Region: VA Regional Office P. O. Box 8888 Muskogee, OK 74402-8888			
SERVES THE FOLLOWING STATES			
AK	AL	AR	AZ
CA	HI	ID	LA
MS	NM	NV	OK
OR	TX	UT	WA
Philippines	Guam	APO/FPO AP	

Southern Region: VA Regional Office P. O. Box 10022 Decatur, GA 30031-7022			
SERVES THE FOLLOWING STATES			
FL	GA	NC	SC
PR	US Virgin Islands	APO/FPO AA	

PRIVACY ACT INFORMATION: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., awards of benefits) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain education benefits. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the maximum benefits allowable under the law. While you do not have to respond, VA cannot process your claim for benefits unless the information is furnished as required by existing law (38 U.S.C. 3513). The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility for education benefits (38 U.S.C. 3513). Title 38 U.S.C. allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at <http://www.reginfo.gov/public/do/PRAMain>. If desired, you can call 1-888-GI-BILL-1 (1-888-442-4551) to get information on where to send comments or suggestions about this form.



DISABLED VETERANS APPLICATION FOR VOCATIONAL REHABILITATION
(Chapter 31, Title 38, U.S.C.)

PURPOSE OF VOCATIONAL REHABILITATION: Vocational Rehabilitation provides services and assistance to certain veterans with disabilities to get and keep a suitable job. If employment is not reasonably feasible, vocational rehabilitation may be able to provide services to support veterans with disabilities to achieve maximum independence in their daily living activities.

IMPORTANT: To see if you should fill out this form, please read the information on back.

1. FIRST, MIDDLE, LAST NAME OF VETERAN	2. SOCIAL SECURITY NO.	3. VA FILE NO. <i>(If different, from Item 2)</i>	4. DATE OF BIRTH <i>(Month, Day, Year)</i>
5A. MAILING ADDRESS <i>(No. and street or rural route, City, State and ZIP Code)</i>	6. DAYTIME TELEPHONE NO. <i>(Include Area Code)</i>	8. VA OFFICE WHERE RECORDS ARE LOCATED	
5B. E-MAIL ADDRESS OF VETERAN <i>(If, available)</i>	7. EVENING TELEPHONE NO. <i>(Include Area Code)</i>	9. NUMBER OF YEARS OF EDUCATION	
10. IF YOU ARE MOVING WITHIN THE NEXT 30 DAYS , GIVE US YOUR NEW ADDRESS	11. LIST ANY PREVIOUS VOCATIONAL REHABILITATION PROGRAMS YOU HAVE BEEN IN AND GIVE THE DATES <i>(Include both VA and non-VA programs)</i>		DO NOT WRITE IN THIS SPACE <i>(VA DATE STAMP)</i>
	PROGRAM	DATE	

12. SERVICE INFORMATION *(Enter the following information for each period of active duty. Show ALL active duty)*

SERVICE NUMBER <i>(Prefix and suffix)</i> (A)	BRANCH OF SERVICE (B)	DATE ENTERED ACTIVE DUTY (C)	DATE LEFT ACTIVE DUTY (D)	TYPE OF SEPARATION OR DISCHARGE (E)

13. IF YOU ARE NOW WORKING *(Enter the following information for your current job)*

A. NAME AND ADDRESS OF EMPLOYER	B. DUTIES OF YOUR JOB	C. MONTHLY SALARY OR WAGES

14. IF YOU ARE NOW HOSPITALIZED, WHAT IS THE NAME AND ADDRESS OF YOUR HOSPITAL?

15A. WHAT IS YOUR DISABILITY RATING?	15B. WHAT IS THE NATURE OF YOUR DISABILITY <i>(DISABILITIES)</i> ?

16. DID YOU SERVE IN: <i>(Check appropriate box(es))</i>			17. DISABLED TRANSITION ASSISTANCE PROGRAM (DTAP)? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> WORLD WAR II	<input type="checkbox"/> POST KOREAN CONFLICT	<input type="checkbox"/> GULF WAR	
<input type="checkbox"/> POST WORLD WAR II ERA	<input type="checkbox"/> VIETNAM	<input type="checkbox"/> OPERATION ENDURING FREEDOM	
<input type="checkbox"/> KOREAN CONFLICT	<input type="checkbox"/> POST VIETNAM	<input type="checkbox"/> OPERATION IRAQI FREEDOM	

I HEREBY CERTIFY THAT the information I have entered on this form is true and complete to the best of my knowledge and belief. I realize that making willful false statements concerning a material fact in a claim of vocational rehabilitation benefits is a punishable offense that may result in fine or imprisonment or both.

18A. SIGNATURE OF APPLICANT <i>(Do not print) (Sign in ink)</i>	18B. DATE SIGNED

VOCATIONAL REHABILITATION FOR SERVICE-DISABLED VETERANS

TO APPLY OR RECEIVE INFORMATION AND ASSISTANCE:

- To apply, submit this completed application to the nearest VA office.
- You may obtain information and assistance from any VA office or on line at <http://www.vba.va.gov/bln/vre/index.htm>.
- Local representative of veteran's service organizations and the American Red Cross also have information and forms available.

EVALUATION : If you have a VA combined service-connected disability rating of 10 percent or more and you apply for vocational rehabilitation, we will provide you a comprehensive evaluation. During this evaluation, a VA counselor will work with you to answer a variety of questions. Such as:

1. Do you meet the basic entitlement requirements?
2. Are you within the time limit for receiving this benefit? (This is generally 12 years from the date VA notified you that you had at least a 10% service-connected disability.)

PLANNING AND COUNSELING: Your counselor must first determine that you meet the entitlement requirements and an employment or independent living goal is reasonably feasible. Then your counselor will help you develop a plan of services and assistance to assist you to reach your employment goal. Counseling will be available throughout your program to help you with problems that may arise.

REHABILITATION SERVICES: Not all vocational rehabilitation programs involve training. You may only need employment services to help you get a suitable job. If a VA counselor determines that you need training to reach your vocational goal, your VA counselor will also determine the number of months of training you need. You may train in a vocational school, a special rehabilitation facility, an apprenticeship program, other on-job training position, a college, or a university.

If training is appropriate, VA will provide medical and dental care treatment, employment assistance to get and keep a suitable job, and other services you may need. If a vocational goal is not currently feasible for you, VA may provide services and assistance to improve your capacity for living independently.

SUPPORT: VA may pay for tuition, fees, books, equipment, tools, or other supplies you need to succeed in your program. During your program, you may qualify for a monthly subsistence allowance to help you meet your living expenses. The allowance you receive depends on your type of training, rate of attendance, and number of dependents. You will receive this allowance in addition to any VA compensation or military retired pay you may receive.

PRIVACY ACT: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e. VA needs the information this form requests to help determine your eligibility to the benefit) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records, published in the Federal Register. Your obligation to respond is required to obtain benefits. Giving us your Social Security Number (SSN) information is mandatory. Applicants are required to provide their SSN under Title 38 USC 5101 (c) (1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect.

RESPONDENT BURDEN: We need this information in order for veterans with compensable service-connected disabilities to apply for vocational rehabilitation under title 38, U.S.C. chapter 31. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at <http://www.reginfo.gov/public/do/PRAMain>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Department of Veterans Affairs		FOR VA USE ONLY	MAIL COMPLETED APPLICATION TO:				
		COE REF. NO.	Atlanta Regional Loan Center Attn: COE (262) P. O. Box 100034 Decatur, GA 30031				
REQUEST FOR A CERTIFICATE OF ELIGIBILITY							
NOTE: Please read information on reverse before completing this form. If additional space is required, attach a separate sheet.							
1. NAME OF VETERAN (First, Middle, Last)		2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER				
4A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Item 4B)		4B. NAME(S) USED DURING MILITARY SERVICE (If different from name in Item 1)					
5. DAYTIME TELEPHONE NUMBER		6. E-MAIL ADDRESS (If applicable)					
7A. ADDRESS (Number and street or rural route, city or P.O., State and ZIP Code)		7B. MAIL CERTIFICATE OF ELIGIBILITY TO: (Complete <u>ONLY</u> if the Certificate is to be mailed to an address different from the one listed in Item 7A.)					
8A. WERE YOU DISCHARGED, RETIRED, OR SEPARATED FROM SERVICE BECAUSE OF DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		8B. VA CLAIM NUMBER (If known)					
MILITARY SERVICE (SEE INSTRUCTIONS FOR PROOF OF SERVICE ON THE NEXT PAGE)							
9A. ARE YOU CURRENTLY ON ACTIVE DUTY? (If you currently serving on active duty, leave the "Date Separated" field blank.) <input type="checkbox"/> YES <input type="checkbox"/> NO							
IMPORTANT: Please provide your dates of service. In many cases eligibility can be established based on data in VA systems. However, it is recommended that proof of service be provided, if readily available. Proof of service is required for persons who entered service after September 7, 1980 and were discharged after serving less than 2 years.		BRANCH OF SERVICE	DATE ENTERED	DATE SEPARATED	OFFICER OR ENLISTED	SERVICE NUMBER (if different from Social Security Number)	
		9B. ACTIVE SERVICE - <i>Do not</i> include any periods of Active Duty for Training or Active Guard Reserve service. <i>Do</i> include any activation for duty under Title 10 U.S.C. (e.g. Reserve or Guard unit mobilized.)					
		9C. RESERVE OR NATIONAL GUARD SERVICE <i>Include</i> any periods of Active Duty for Training (ADT) or Active Guard Reserve service. <i>Do not</i> include any activation for duty under Title 10 U.S.C. (e.g. Reserve or Guard unit mobilized.)					
PREVIOUS VA LOANS (SEE INSTRUCTIONS ON THE NEXT PAGE - Attach a separate sheet if information for all homes will not fit in Item 10)							
10A. DO YOU NOW OWN ANY HOME(S) PURCHASED OR REFINANCED WITH A VA-GUARANTEED LOAN? <input type="checkbox"/> YES (If "Yes," complete Items 10B through 10D) <input type="checkbox"/> NO (If "No," skip to Item 14) <input type="checkbox"/> NOT APPLICABLE (NA) - I HAVE NEVER OBTAINED A VA-GUARANTEED HOME LOAN (If "NA," skip to Item 14)		10B. DATE OF LOAN (Month and Year)	10C. STREET ADDRESS		10D. CITY AND STATE		
11A. ARE YOU APPLYING FOR THE ONE-TIME ONLY RESTORATION OF ENTITLEMENT TO PURCHASE ANOTHER HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 11B through 11D)		11B. DATE OF LOAN (Month and Year)	11C. STREET ADDRESS		11D. CITY AND STATE		
12A. ARE YOU APPLYING FOR A RESTORATION OF ENTITLEMENT TO OBTAIN A REGULAR (CASH-OUT) REFINANCE ON YOUR CURRENT HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 12B through 12D)		12B. DATE OF LOAN (Month and Year)	12C. STREET ADDRESS		12D. CITY AND STATE		
13A. ARE YOU REFINANCING AN EXISTING VA LOAN TO OBTAIN A LOWER INTEREST RATE WITHOUT RECEIVING ANY CASH PROCEEDS (IRRRL)? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 13B through 13D)		13B. DATE OF LOAN (Month and Year)	13C. STREET ADDRESS		13D. CITY AND STATE		
I CERTIFY THAT the statements in this document are true and complete to the best of my knowledge.							
14A. SIGNATURE OF VETERAN (Do NOT print)					14B. DATE SIGNED		
FEDERAL STATUTES PROVIDE SEVERE PENALTIES FOR FRAUD, INTENTIONAL MISREPRESENTATION, CRIMINAL CONNIVANCE OR CONSPIRACY PURPOSED TO INFLUENCE THE ISSUANCE OF ANY GUARANTY OR INSURANCE BY THE SECRETARY OF VETERANS AFFAIRS							
FOR VA USE ONLY (Please do not write below this line)					DATE RETURNED		
REASON(S) FOR RETURN							

INSTRUCTIONS FOR VA FORM 26-1880

PRIVACY ACT NOTICE - VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (for example: the authorized release of information to Congress when requested for statistical purposes) identified in the VA system of records, 55VA26, Loan Guaranty Home, Condominium and Manufactured Home Loan Applicant Records, Specially Adapted Housing Applicant Records, and Vendee Loan Applicant Records - VA, and published in the Federal Register. Your obligation to respond is required in order to determine the qualifications for a loan.

RESPONDENT BURDEN - This information is needed to help determine a veteran's qualifications for a VA guaranteed home loan. Title 38, U.S.C., section 3702, authorizes collection of this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

A. YOUR IDENTIFYING INFORMATION

Item 1 - Tell us your complete name, *as you would like it to appear on your Certificate of Eligibility (COE)*.

Item 4B - If you served under another name, provide the name as it appears on your discharge certificate (DD Form 214).

Item 7 - You can have your Certificate of Eligibility sent to you at your current mailing address, or directly to your lender, or to any mailing address you provide in Item 7B.

Item 8B - In most cases, your VA claim number is the same as your Social Security Number. If you are not sure of your VA claim number, leave this field blank.

B. MILITARY SERVICE

Item 9 - **NOTE** - Cases involving other than honorable discharges will usually require further development by VA. This is necessary to determine if the service was under other than dishonorable conditions.

Item 9A - If you are currently serving on regular active duty, eligibility can usually be established based on data in VA systems. However, in some situations you may be asked to provide a statement of service signed by, or by direction of, the adjutant, personnel officer, or commander of your unit or higher headquarters. The statement may be in any format; usually a standard or bulleted memo is sufficient. It should identify you by name and social security number, and provide: (1) your date of entry on your current active duty period and (2) the duration of any time lost (or a statement noting there has been no lost time). Generally this should be on military letterhead.

Item 9B - **Active Service (not including Active Duty Training or Active Guard Reserve service)** - the best evidence to show your service is your discharge certificate (DD Form 214) showing active duty dates and type of discharge. If you were separated after October 1, 1979, the DD214 was issued in several parts (copies). We are required to have a copy showing the character of service (Item 24) and the narrative reason for separation (Item 28). We prefer the MEMBER-4 copy, however, we can accept any copy that contains these items. The copy number is shown on the bottom right of the form. We don't need the original; a photocopy is acceptable. Any Veterans Services Representative in the nearest Department of Veterans Affairs office or center will assist you in securing necessary proof of military service.

NOTE - A reservist or member of the National Guard can be called to active duty under either of two legal authorities. Title 10 U.S. Code covers those who are ordered to regular active duty under federal call up. Reservists may also be called to active service under the authority of Title 32 U.S. Code. Service covered under Title 32 U.S. Code includes basic training (Initial Active Duty for Training or IADT) annual training, as well as certain types of full-time duty may be called Active Guard Reserve, Active Duty for Special Work, Full-time National Guard Duty or Active Duty Support. Service under Title 10 U.S. Code is qualifying active duty for the VA Home Loan Benefit. Active service under Title 32 U.S. Code, however, does NOT qualify under the active duty requirements. Service under Title 32 U.S. Code can be used to meet the 6-year requirement to qualify as a member of the Selected Reserve or National Guard.

Item 9C - **National Guard Service:** You may submit NGB Form 22, Report of Separation and Record of Service, or NGB Form 23, Retirement Points Accounting, or their equivalent. We are required to have a copy showing character of service.

Selected Reserve Service (Including Active Duty Training and Active Guard Reserve) - You may submit (Including Active Duty Training and Active Guard Reserve) a copy of your latest annual retirement points statement and evidence of honorable service. There is no single form used by the Reserves similar to the DD Form 214 or NGB Form 22. The following forms are commonly used, but others may be acceptable:

Army Reserve	DARP FM 249-2E
Naval Reserve	NRPC 1070-124
Air Force Reserve	AF 526
Marine Corps Reserve	NA VMC 798
Coast Guard Reserve	CG 4174 or 4175

If you are still serving in the Selected Reserves or the National Guard, you must include an original statement of service signed by, or by the direction of, the adjutant, personnel officer, or commander of your unit or higher headquarters showing your date of entry and the length of time that you have been a member of the Selected Reserves. At least 6 years of honorable service must be documented.

C. PREVIOUS VA LOANS

Items 10 through 14. Your eligibility is reusable depending on the circumstances. Normally, if you have paid off your prior VA loan and no longer own the home, you can have your used eligibility restored for additional use. Also, on a one-time only basis, you may have your eligibility restored if your prior VA loan has been paid in full but you still own the home. Normally VA receives notification that a loan has been paid. In some instances, it may be necessary to include evidence that a previous VA loan has been paid in full. Evidence can be in the form of a paid-in-full statement from the former lender, a satisfaction of mortgage from the clerk of court in the county where the home is located, or a copy of the HUD-1 settlement statement completed in connection with a sale of the home or refinance of the prior loan. Many counties post public documents (like the satisfaction of mortgage) online.

Item 11A. **One-Time Restoration.** If you have paid off your VA loan, but still own the home purchased with that loan, you may apply for a one-time only restoration of your entitlement in order to purchase another home that will be your primary residence. Once you have used your one-time restoration, you must sell all homes before any other entitlement can be restored.

Item 12A. **Regular (cash-out) Refinance.** You may refinance your current VA or non-VA loan in order to pay off the mortgage and/or other liens of record on the home. This type of refinance requires an appraisal and credit qualifying.

Item 13A. **Interest Rate Reduction Refinancing Loan (IRRRL).** You may refinance the balance of your current VA loan in order to obtain a lower interest rate, or convert a VA adjustable rate mortgage to a fixed rate. The new loan may not exceed the sum of the outstanding balance on the existing VA loan, plus allowable fees and closing costs, including VA funding fee and up to 2 discount points. You may also add up to \$6,000 of energy efficiency improvements into the loan. **A certificate of eligibility is not required for IRRRL.** Instead, a Prior Loan Validation, obtained through our online system WebLGY can be used in lieu of a COE. Presently, this application is only available to lenders. In WebLGY, a lender can select Eligibility from the toolbar and then Prior Loan Validation. Enter the veteran's Social Security Number and Last Name. The system will then, in most cases, pull up the veteran's active loan information. Print the prior Loan Validation screen and use it in lieu of the COE.

INFORMATION AND INSTRUCTIONS FOR COMPLETING THE VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

IMPORTANT- Please read the information below carefully to help you complete this form more quickly and accurately. Some parts of the form also contain notes or specific instructions for completing that part.

Frequently Asked Questions

For what do I use VA Form 21-526?

Use VA Form 21-526 to apply for compensation and/or pension benefits.

Should I apply for compensation or pension benefits?

You should apply for **compensation** benefits if:

- You currently have a disability that is the result of an injury, disease, or an event in military service.

You should apply for **pension** benefits if *all* of the following are true:

- You are age 65 or older or are permanently and totally disabled.
- You served on active duty with at least one day during a period of war.
- Your income and net worth does not exceed certain limits. Visit our website, <http://www.vba.va.gov/bln/21/rates> for the maximum yearly income we allow.

Note: Attach current medical evidence showing that you are permanently and totally disabled.

IMPORTANT: If you are a veteran who is age 65 or older, or determined to be disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application unless you are filing for special monthly pension. Special monthly pension is an allowance that may be paid to individuals who, due to mental or physical disability, require the assistance of another person to perform the basic activities of daily living, or their ability to leave home is very limited.

May I apply electronically?

To file a claim for VA compensation or pension electronically, please complete and submit VA Form 21-526, Veteran's Application for Compensation and/or Pension, using VONAPP. The VONAPP (Veterans On Line Application) website is an official U.S. Department of Veterans Affairs (VA) website that enables service members, veterans and their beneficiaries, and other designated individuals to apply for benefits using the Internet. You can apply online at our website, <http://vabenefits.vba.va.gov/vonapp/main.asp>.

What parts of the form should I complete?

You should complete only the parts related to the benefit for which you are applying:

- If you are applying for compensation **ONLY**, skip parts VII, VIII, IX, X.
- If you are applying for pension, complete the **ENTIRE** form.
- If you need more space to answer a question or have a comment about a specific item on this form, please place it in Part XIII, Item 45, "Remarks." Please identify your answer or comment by the part and item number.

Where can I get help?

You can ask VA to help you fill out the form by contacting a regional office or call center. Before you contact us, make sure you gather the necessary materials and complete as much of the form as you can. You can contact VA in the following ways:

- **By internet:** <https://iris.va.gov>
- **In person:** You can locate the address of the closest regional office on the website <http://www.va.gov/directory> or in your telephone book blue pages under "**United States Government, Veterans**"
- **By telephone:** Please call one of the following telephone numbers:
1-800-827-1000
1-800-829-4833 (Hearing Impaired TDD line)
1-412-395-6272 (If living outside the U.S.)

You can also contact a county or national veterans' service organization (VSO) representative to help you with your claim. If you want to use a representative to help you, consult your local telephone book to contact a particular VSO or contact the closest VA office. Depending on the type of representative you want to designate, we will send you one of the following forms:

- VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative
- VA Form 21-22A, Appointment of Individual as Claimant's Representative

What should I do when I have finished my application?

- You should provide your signature in Part XII, Item 42A. Be sure to sign every form you fill out before you send it to us. If you don't sign the form, VA will return it for you to sign, and it will take longer for us to process.
- Attach any materials that support and explain your claim.
- Mail or take your application to the closest VA regional office. VA regional office addresses are available on the internet at <http://www.va.gov/directory>

Do I need to keep a copy of my application?

It is important that you keep a copy of all completed forms and materials you give to VA.

Social Security and Supplemental Security Income Benefits

Social Security and Supplemental Security Income are two Federal programs that help people with disabilities. While these programs are different in many ways, the Social Security Administration (SSA) administers both programs. If you think you have a disabling condition, you may qualify for benefits under one or both of these programs and should contact Social Security.

How can I contact SSA if I have questions?

You can find answers to most questions and file a claim online at www.socialsecurity.gov. Specific information is available for active duty military, veterans, and their families at www.socialsecurity.gov/woundedwarriors.

You can also contact SSA in the following ways:

- **By phone:** (Monday-Friday, 7 a.m. - 7 p.m. EST) at one of the following toll-free numbers:
1-800-772-1213
1-800-325-0778 (TTY if you are deaf or hard of hearing)
- **By mail or in person:** You can locate the address of the Social Security office nearest to you in your telephone book blue pages under "**United States Government, Social Security Administration**".

Part II - Nature and History of Service-Related Disability(ies)

What disabilities should I list?

List the disease(s) or medical condition(s) that form the basis of your claim for service connected compensation. Be as specific as you can. Indicate the approximate date the disability began and the place of treatment.

Do I have to include any records with this claim form?

If you have records that support your claim, you should attach them to this form. VA will help you obtain records by requesting them from the person, company, or agency that has them. On this form you must tell us the name and address of the person, company or agency that has these records, the approximate time frame covered by them, and the condition for which you were treated. If you received treatment from a non-VA health care provider complete the attached VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). We will use this form to request these records. Due to Privacy Act regulations, please use only one source of information (Item 7) on each form, as some medical offices will not accept the forms otherwise, which may cause a delay in processing your claim. Additional 21-4142 forms can be obtained from the VA forms website at www.va.gov/vaforms.

Part III - Active Duty Service Information

Do I need to include my active duty service information?

Please provide the information for each period of active duty (provide a copy of your DD214 or other separation papers for all periods of active duty service).

Part IV - Reserve and National Guard Service Information

What If I have Reserve or National Guard Service?

This section tells us if you were a member of the Reserve or National Guard. Complete information for each period of Reserve and National Guard service. Provide a copy of your DD214 or other separation papers for all periods of active service.

Part V - Military Retired/Severance Pay

What If I have received or will receive military pay?

This section asks about your military severance or separation pay, the type, and the amount. If you currently receive military retired pay, we may reduce your retired pay by the amount of any compensation that we award. It is to your advantage because VA compensation is not taxable while retired pay is taxable. However, if you wish to receive military retired pay rather than VA compensation, you must check the box in Item 25. Some veterans receive various readjustment, separation, or severance pay from service departments which may be recouped in full or in part from VA benefit payments.

Part VI - Marital and Dependency Information

Who can I count as a dependent spouse?

A spouse is a person of the opposite sex who is married to the veteran (authority: 38 U.S.C. subsection 101(31)). The marriage must be valid under the law of the place where the parties resided at the time of marriage, or the law of the place where the parties resided when the right to benefits occurred.

Note: It is important that you provide your marital history and that of your spouse.

Who can be recognized as a dependent child?

VA recognizes the veteran's biological child, adopted child, and stepchild. However, the child must be unmarried and:

- under the age of 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- permanently incapable of self support before reaching the age of 18.

Part VII - Non-Service Connected Pension

This section asks you to provide the disabilities that prevent you from working. We also ask you to tell us if you require the regular assistance of another person, if you are housebound, if you are in a nursing home, if you are in receipt of Social Security, or if you have applied for Medicaid.

Part VIII - Income Information

This section asks you to provide specific information about the monthly income you and your dependants receive from all sources. Report the gross amount you receive monthly before deductions are taken out for taxes, health care, insurance, etc. Do **not** leave any blank boxes in this section! Complete each box with either a dollar figure, "0", or "none." If you expect to receive payment, but you don't know how much it will be, write "Unknown" in the space. If you are not sure about a particular type of income, report it and provide a full explanation of its source. If you are receiving monthly benefits from any source and have a copy of your most recent award letter, please include a copy of the letter with your application.

Part IX - Net Worth

This section asks you to provide specific information about your net worth and that of your dependents. **Do not leave any blank boxes in this section!** Complete each box with either a dollar figure, "0", or "none."

Net worth is the market value of all interest and rights in any kind of property, after subtracting any mortgages and other claims against the property. List all assets except the house in which you live, any reasonable area of land on which it sits, and those items you use everyday, such as your vehicle, clothing and furniture.

Clearly indicate if you and your spouse jointly share assets (such as money in a joint checking account). Report the value of farms or buildings that you or a dependent owns as "real property."

You must disclose all financial transactions that involve a transfer of assets, even if the transaction occurred prior to the date of your application for VA pension. A gift of property or a sale below the property's value to a relative residing in the same household does not reduce net worth. Likewise, a gift of property to someone other than a relative residing in your household does not reduce net worth unless it is clear that you have relinquished all rights of ownership, including the right to control the property.

Part X - Medical, Legal or Other Expenses

When determining your eligibility for pension, we may be able to deduct unreimbursed medical expenses from your income for the year in which the expenses are paid. Report the amount of unreimbursed medical expenses, including the Medicare deductions you paid (out-of-pocket) for yourself or relatives you are under an obligation to support. Also, show medical, legal, or other expenses you paid because of a disability for which civilian disability benefits have been awarded. **Do not** report any expenses you did not pay or expenses for which you were or will be reimbursed.

PRIVACY ACT INFORMATION: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary; however, no allowance of compensation or pension may be granted unless this form is completed fully as required by law. Giving us you and your dependents' Social Security numbers is mandatory. Applicants are required to provide their SSN and the SSN of any dependents for whom benefits are claimed under Title 38 USC 5101 (c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other Federal or state agencies. Income and employment information furnished by you will be compared with information obtained by VA from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103(1)(7)(D) of the Internal Revenue Code of 1986.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation and/or pension (38 U.S.C. 5101). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



IMPORTANT - Read information and instructions carefully before completing the form. Type, print, or write plainly.

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

PART I - VETERAN'S INFORMATION

1. FOR WHAT BENEFIT ARE YOU APPLYING?

COMPENSATION PENSION BOTH COMPENSATION AND PENSION

2. HAVE YOU PREVIOUSLY APPLIED FOR ANY VA BENEFIT(S)? (Check applicable box)

PENSION COMPENSATION OTHER (Specify)

3. FIRST, MIDDLE, LAST NAME OF VETERAN

4A. VETERAN'S SOCIAL SECURITY NO.

4B. VA FILE NUMBER (If applicable)

4C. SPOUSE'S SOCIAL SECURITY NO.

4D. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NO.

5. MAILING ADDRESS (Number and street or rural route, city or P.O., State and ZIP Code)

6. TELEPHONE NUMBER(S) (Include Area Code)

7. E - MAIL ADDRESS (If applicable)

A. DAYTIME

B. EVENING

C. CELL

8A. DATE OF BIRTH (Month, day, year)

8B. PLACE OF BIRTH

9. SEX

MALE FEMALE

10A. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? (Formerly the U.S. Bureau of Employees Compensation)

YES NO (If "Yes," complete Items 10B & 10C)

10B. WHEN WAS THE CLAIM FILED? (Mo., day, yr.)

10C. FOR WHAT DISABILITY ARE YOU RECEIVING BENEFITS?

PART II - NATURE AND HISTORY OF SERVICE-RELATED DISABILITY(IES) - If you need more space please use Item 45, "Remarks"

11. PLEASE PROVIDE NATURE OF SICKNESS, DISEASE, OR INJURIES FOR WHICH THIS CLAIM IS MADE; DATE EACH BEGAN; AND PLACE OF TREATMENT

A. LIST DISABILITY(IES)

B. DATE BEGAN

C. PLACE OF TREATMENT

12A. ARE YOU NOW OR HAVE YOU RECEIVED TREATMENT OR DOMICILIARY CARE AT A VA MEDICAL FACILITY?

YES NO (If "Yes," complete Items 12B & 12C)

12B. DATES OF TREATMENT/CARE

Month Day Year

12C. NAME AND ADDRESS OF VA MEDICAL FACILITY (If you need more space use Item 45, "Remarks")

13A. HAVE YOU EVER BEEN A PRISONER OF WAR?

YES NO (If "Yes," complete Items 13B and 13C)

13B. NAME OF COUNTRY

13C. DATES OF CONFINEMENT

FROM

TO

14. ARE YOU CLAIMING A DISABILITY RELATED TO AGENT ORANGE OR OTHER HERBICIDE EXPOSURE? (If "Yes," list disability(ies) below)

YES NO

15. ARE YOU CLAIMING A DISABILITY RELATED TO ASBESTOS EXPOSURE? (If "Yes," list disability(ies) below)

YES NO

16. ARE YOU CLAIMING A DISABILITY RELATED TO MUSTARD GAS EXPOSURE? (If "Yes," list disability(ies) below)

YES NO

17. ARE YOU CLAIMING A DISABILITY RELATED TO IONIZING RADIATION EXPOSURE? (If "Yes," list disability(ies) below)

YES NO

18. ARE YOU CLAIMING A DISABILITY RELATED TO AN ENVIRONMENTAL HAZARD EXPOSURE DURING THE GULF WAR? (If "Yes," list disability(ies) below)

YES NO

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART III - ACTIVE DUTY SERVICE INFORMATION

NOTE: Please complete the information for each period of active duty. Attach DD214 or other separation papers for all periods of active duty. If you do not have your DD214 form or other separation papers, check the box.

19A. ENTERED INTO SERVICE		19B. SERVICE NUMBER	19C. SEPARATED FROM SERVICE		19D. BRANCH OF SERVICE	19E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

PART IV - RESERVE AND NATIONAL GUARD SERVICE INFORMATION

NOTE: Enter complete information for each period of Reserves and National Guard service. Attach any separation papers you have.

20A. ENTERED INTO SERVICE		20B. SERVICE NUMBER	20C. SEPARATED FROM SERVICE		20D. SERVICE STATUS <i>(Reserve, National Guard)</i>	20E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

21. IF DISABILITY OCCURRED DURING ACTIVE OR INACTIVE DUTY FOR TRAINING, GIVE BRANCH OF SERVICE AND DATE OF OCCURRENCE	22A. ARE YOU NOW A MEMBER OF THE RESERVES OR NATIONAL GUARD? IF SO, GIVE THE BRANCH OF SERVICE <input type="checkbox"/> YES <input type="checkbox"/> NO BRANCH _____	22B. RESERVE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RESERVE OBLIGATION <input type="checkbox"/> INACTIVE
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22C. NAME, ADDRESS AND PHONE NO. OF RESERVE OR NATIONAL GUARD UNIT *(If additional space is needed, use Item 45 "Remarks")*

PART V - MILITARY RETIRED/SEVERANCE PAY

IMPORTANT - Unless you check the box in Item 25 below, you are telling us that you are choosing to receive VA compensation instead of military retired pay, if it is determined you are entitled to both benefits. If you are awarded military retired pay prior to compensation, we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. If you receive both military retired pay and VA compensation, some of the amount you receive may be recouped by VA, or, in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.

23A. ARE YOU RECEIVING MILITARY RETIRED PAY? <i>(If "Yes," complete Items 23C & 23D)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	23B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE? <i>(If "Yes," explain, i.e. Future Reserve/National Guard Retirement, Pending MEB/PEB)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO _____	23C. BRANCH OF SERVICE	23D. MONTHLY AMOUNT \$
--	--	------------------------	-------------------------------

24. RETIRED STATUS
 RETIRED TEMPORARY DISABILITY RETIRED LIST DISABLED RETIRED LIST 25. NO, I DO NOT WANT VA COMPENSATION IN LIEU OF MILITARY RETIRED PAY
 (Check box, if applicable)

26. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE/SEPARATION PAY, OR ANY OTHER LUMP SUM PAYMENT FROM THE ARMED FORCES?
(If "Yes," list type, amount, date it was received, and the branch of service below)
 YES NO _____

PART VI - MARITAL AND DEPENDENCY INFORMATION

27A. MARITAL STATUS *(If married, complete Items 27B thru 29D)*
 MARRIED WIDOWED DIVORCED NEVER MARRIED *(If never married, skip to Item 30)*

27B. SPOUSES'S BIRTHDATE *(Mo., day, yr.)*

27C. NUMBER OF TIMES YOU HAVE BEEN MARRIED <i>(To include current marriage)</i>	27D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED <i>(To include current marriage)</i>	27E. IS YOUR SPOUSE ALSO A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Item 27F)</i>	27F. SPOUSE'S VA FILE NUMBER <i>(If any)</i>
--	--	--	--

27G. DO YOU LIVE TOGETHER? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "No," complete Items 27H thru 27J)</i>	27H. REASON FOR SEPARATION <i>(For example, marital problems, job requirements, health, etc.)</i>	27I. PRESENT ADDRESS OF SPOUSE
--	---	--------------------------------

27J. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S MONTHLY SUPPORT \$	27K. HOW WERE YOU MARRIED? <input type="checkbox"/> CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL <input type="checkbox"/> TRIBAL <input type="checkbox"/> OTHER <i>(Explain)</i> <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> PROXY _____
---	--

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART VI - MARITAL AND DEPENDENCY INFORMATION - CONTINUED (If you need additional space, use Item 45 "Remarks")

FURNISH THE FOLLOWING INFORMATION ABOUT EACH OF YOUR MARRIAGES (IF NOT APPLICABLE, WRITE "N/A")

28A. DATE AND PLACE OF MARRIAGE		28B. TO WHOM MARRIED	28C. TERMINATED (Death, Divorce)	28D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE (IF NOT APPLICABLE, WRITE "N/A")

29A. DATE AND PLACE OF MARRIAGE		29B. TO WHOM MARRIED	29C. TERMINATED (Death, Divorce)	29D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

DEPENDENCY - Dependent Children Information (If you need additional space, use Item 45 "Remarks")

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN

30A. NAME OF CHILD (First, middle initial, last)	30B. DATE & PLACE OF BIRTH (City, state or country)	30C. SOCIAL SECURITY NUMBER	30D. CHECK EACH APPLICABLE CATEGORY					
			BIOLOGICAL	ADOPTED	STEPCHILD	18-23 YRS. OLD AND IN SCHOOL	SERIOUSLY DISABLED BEFORE AGE 18	CHILD PREVIOUSLY MARRIED
	_____ (Month, day, year) Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ (Month, day, year) Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ (Month, day, year) Place:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN WHO DO NOT LIVE WITH YOU

31A. NAME(S) OF ANY CHILD(REN) NOT IN YOUR CUSTODY	31B. NAME AND ADDRESS OF PERSON HAVING CUSTODY	31C. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
		\$
		\$

PART VII - NON-SERVICE CONNECTED PENSION (If you need additional space use Item 45 "Remarks")

NOTE: You do not have to submit medical evidence or list disabilities if you are age 65 or older, unless you are housebound, or require the regular assistance of another person.

32. WHAT DISABILITIES PREVENT YOU FROM WORKING? (List below)	33. DO YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON OR ARE YOU GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO
--	--

NURSING HOME INFORMATION

NOTE: You may submit a statement by an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.

34A. ARE YOU NOW IN A NURSING HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "YES," complete Items 34B thru 34D)</i>	34B. NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY	34C. HAVE YOU APPLIED FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO
34D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED AND NOT RECEIVED A DECISION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> APPLIED - NOT RECEIVED DECISION	34E. ARE YOU RECEIVING SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) OR HAVE YOU APPLIED FOR SSI BUT NO DECISION HAS BEEN MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> APPLIED - NOT RECEIVED DECISION	

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART VIII - INCOME INFORMATION *(Provide the income you received from all sources)*

NOTE: Report the total income before deductions for taxes, insurance, etc. If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space. If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid. Payments from any source will be counted, unless the law says that they don't need to be counted.

MONTHLY INCOME - Provide the income that you and your dependents receive every month. For items 35A -35F, if none, write "0" or "NONE." Do not leave blank spaces.

ITEM NO.	SOURCES OF RECURRING MONTHLY INCOME	VETERAN	SPOUSE	CHILD(REN) <i>(Provide the first, middle initial, and last name)</i>		
				NAME	NAME	NAME
35A.	Social Security					
35B.	U.S. Civil Service					
35C.	U.S. Railroad Retirement					
35D.	Military Retired Pay					
35E.	Black Lung Benefits					
35F.	Other <i>(Interest, dividends, or one-time payments)</i>					
36A. WILL YOU RECEIVE ANY INCOME FROM RENTAL PROPERTY OR FROM THE OPERATION OF A BUSINESS WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM? <input type="checkbox"/> YES <input type="checkbox"/> NO		36B. WILL YOU RECEIVE ANY INCOME FROM THE OPERATION OF A FARM WITHIN 12 MONTHS OF THE DAY YOU SIGN THIS FORM? <input type="checkbox"/> YES <input type="checkbox"/> NO		36C. DO YOU THINK YOUR INCOME WILL CHANGE IN THE NEXT 12 MONTHS? <i>(If "Yes," explain below)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO _____		

PART IX - NET WORTH *(Provide specific information about the net worth of you and your dependents)*

NET WORTH is the market value of all interest and rights in any kind of property after subtracting any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal items such as your vehicle, clothing, and furniture.

NOTE: For items 37A-37F provide amounts. If none, write "0" OR "NONE." Do not leave blank spaces.

ITEM NO.	SOURCE	VETERAN	SPOUSE	CHILD(REN) <i>(Provide the first, middle initial, and last name)</i>		
				NAME	NAME	NAME
37A.	Cash, non-interest bearing bank accounts					
37B.	Interest bearing bank accounts, certificates of deposit <i>(CDs)</i>					
37C.	Retirement accounts <i>(IRAs, Keogh Plans, etc.)</i>					
37D.	Stocks, bonds, and mutual funds					
37E.	Value of business assets					
37F.	Real property <i>(not your home)</i>					

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.

PART X - MEDICAL, LEGAL, OR OTHER EXPENSES

IMPORTANT - Complete items 38A through 38E only if you are applying for nonservice connected pension.

MEDICAL, LEGAL OR OTHER EXPENSES - Family medical expenses you actually paid (out-of-pocket) may be deducted from your income. Show the amount of unreimbursed medical expenses you paid for dependents you are under an obligation to support. Also, show medical, legal, or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to increase benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. Be sure to include the Medicare deduction. If more space is needed, you may use Item 45, "Remarks" or attach a separate sheet.

38A. AMOUNT YOU PAID	38B. DATE PAID <i>(Month, year)</i>	38C. PURPOSE <i>(Doctor's fees, hospital charges, attorney fees, etc.)</i>	38D. PAID TO <i>(Name of doctor, hospital, pharmacy, attorney, etc.)</i>	38E. PERSON FOR WHOM EXPENSE PAID <i>(Self, spouse, child)</i>

PART XI - DIRECT DEPOSIT

Generally, all Federal payments are required to be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 39, 40, and 41 to enroll in direct deposit. If you do not have a bank account you can receive a waiver from direct deposit, by checking the box below in Item 39. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in direct deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee, OK 74401-7004, and give us a brief description of why you do not wish to participate in direct deposit.

39. ACCOUNT NUMBER *(Please check the appropriate box and provide the account number, if applicable)*

CHECKING _____
(Account Number)

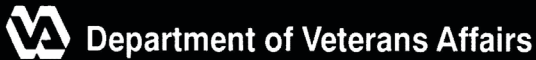
SAVINGS _____
(Account Number)

I certify that I do not have an account with a financial institution or certified payment agent

40. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit to go)*

41. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check or savings deposit slip)*

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 42A THRU 42C ON PAGE 10.



AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

RESPONDENT BURDEN: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000
 (TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN <i>(Type or print)</i>	2. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME <i>(If other than Veteran)</i> LAST NAME, FIRST, MIDDLE	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC. <i>(Include ZIP Codes, and also a telephone number, if available)</i>	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS, OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC <i>(Include month and year)</i>	7C. CONDITION(S) <i>(List illness, injury, etc. pertinent to your claim)</i>

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 9C.

SECTION III - CONSENT TO RELEASE INFORMATION

READ ALL PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 9C.

9A. Privacy Act Notice: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provided a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the health care provider or health plan identified in Item 7A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 7A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If you do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

9C. I (AUTHORIZE) (DO NOT AUTHORIZE) the source shown in Item 7A to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia or psychotherapy notes. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

10A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	10B. RELATIONSHIP TO VETERAN/CLAIMANT <i>(If other than self, please provide full name, title, organization, city, State and ZIP Code. All court appointments must include docket number, county and State)</i>	10C. DATE
--	--	-----------

10D. MAILING ADDRESS <i>(Number and Street or rural route, city, or P.O. State and ZIP Code)</i>	10E. TELEPHONE NUMBER <i>(Include Area Code)</i>
--	--

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

11A. SIGNATURE OF WITNESS	11B. DATE
---------------------------	-----------

11C. MAILING ADDRESS OF WITNESS



**GENERAL INSTRUCTIONS
FOR INCOME-NET WORTH AND EMPLOYMENT STATEMENT
VA FORM 21-527**

Note: Read very carefully, detach, and keep these instructions for your reference.

A. How can I contact VA if I have questions?

If you have questions about this form, how to fill it out, or about benefits, contact your nearest VA regional office. You can locate the address of the nearest regional office in your telephone book blue pages under "United States Government, Veterans" or call 1-800-827-1000 (Hearing Impaired TDD line 1-800-829-4833). You may also contact VA by Internet at <http://www.vba.va.gov/benefits/address.htm>.

B. What do I use VA Form 21-527 for?

Use VA Form 21-527 to apply for disability pension if you have previously filed a claim for compensation and/or pension. If you have not filed a claim for compensation or pension previously, you must use VA Form 21-526, Veteran's Application for Compensation and/or Pension.

C. What is disability pension and how does VA decide what I will or will not receive?

You should apply for pension benefits if *all* of the following are true:

- Your income is limited.
- You are permanently and totally disabled (but not as a result of your military service).
- At least part of your active duty was during a wartime period.

VA pays disability pension based on the amount of income that the veteran and family receive and the number of dependents in the family. This is based on law. VA must include as income all sources that federal law specifies. You can find out what the current income limitations and rates of benefits are by contacting your nearest VA office.

Benefits may only be paid from the date of receipt of your application in VA unless you were incapacitated because of a disability which prevented you from filing a claim for a period of at least 30 days beginning with the date you became permanently and totally disabled. If you want this claim considered as a claim for retroactive payment, so indicate in Item 42, "Remarks," and identify the specific disability which prevented you from filing.

D. What is special monthly pension?

VA may pay a higher rate of disability pension to a veteran who is blind, a patient in a nursing home, otherwise needs regular aid and attendance, or who is permanently confined to his or her home because of a disability. If you wish to apply for this benefit, check "Yes" for Item 24.

E. What medical evidence should I submit?

Furnish current medical evidence showing that you are permanently and totally disabled.

Note: If you are age 65 or older or determined to be disabled by the Social Security Administration, you do not have to submit medical evidence with your application unless you are claiming special monthly pension.

If you wish to claim special monthly pension and are not in a nursing home, furnish a statement from your doctor showing the extent of your disabilities. If you are in a nursing home, attach a statement signed by an official of the nursing home showing the date you were admitted to the nursing home, the level of care you receive, and whether Medicaid covers all or part of your nursing home costs.

If you want help getting existing medical records, you may complete VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). By signing VA Form 21-4142, you authorize any doctors, hospitals, or caregivers that have treated you to release information about your treatment to VA. You do not need to complete this form for any treatment you received at a VA facility. If you need a copy of this form, you may contact VA as shown under Item A, or download the form from our website at <http://www.va.gov/vaforms/>.

F. How do I complete my application?

Print all answers clearly. If you must write the answers do so very clearly and plainly. If an answer is "none" or "0," write that. Your answer to every question is important to help us complete your claim. If you do not know the answer, write "unknown." For additional space, use Item 42, "Remarks," or attach a separate sheet, indicating the item number to which the answers apply. Make sure you sign and date this application (Items 38 and 39).

G. What do I do when I have completed my application?

When you have completed this application mail it or take it to a VA regional office. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and everything that you submit to VA before you mail it.

H. How can I assign someone to act as my representative?

A representative can be an accredited member of an accredited organization or other service organization that the Secretary of Veterans Affairs recognizes, an agent recognized by VA, or a licensed lawyer. Agents and attorneys can charge you for services that you get from them only after the Board of Veterans' Appeals (BVA) gives you their final decision about your application. That means you can use an attorney during any stage of your application for benefits. However, the agent or attorney cannot charge you for services unless you are trying to resolve a dispute with VA after BVA has made a decision about your claim.

If you want to use a representative to help you with your application, contact the nearest VA office. Depending on the type of representative you want to designate, we will send you one of the following forms:

VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative, or VA Form 22A, Appointment of Individual as Claimant's Representative. You may also download these forms at <http://www.va.gov/vaforms/>. If you have already designated a representative, no further action is required on your part.

I. What if I believe that VA has made an error in processing or deciding my benefits?

You can ask for a personal hearing at any time during the processing of your claim. That means you can ask for the hearing while VA is processing your claim or after VA has made a decision. You should contact the nearest VA office and tell them that you want a personal hearing on your case. Someone in the local VA office will arrange a time and a place for your hearing. At this hearing, you can bring witnesses. VA will record whatever you and your witnesses say during the hearing and include it in the official record. VA will furnish the hearing room and officials, and prepare a transcript of the hearing. VA cannot pay your expenses or the expenses of anyone you want to bring with you to the hearing.

Privacy Act Notice: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22 Compensation, Pension, Education, and Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your SSN account information is mandatory. Applicants are required to provide their SSN under Title 38 USC 5101 (c) (1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U. S. C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

(DO NOT WRITE IN THIS SPACE)

**INCOME-NET WORTH AND EMPLOYMENT STATEMENT
VA FORM 21-527**

Please read the attached "General Instructions" before you fill out this form.

SECTION I Tell us about you	1. What is your name? <hr/> <div style="display: flex; justify-content: space-between; font-size: small;"> First Middle Last Suffix (If applicable) </div>	
	2. What is your Social Security number? <hr/>	3. What is your VA file number? <hr/>
	4. What is your address? <hr/> <div style="display: flex; justify-content: space-between; font-size: small;"> Street address, Rural Route, or P.O. Box Apt. number </div> <hr/> <div style="display: flex; justify-content: space-between; font-size: small;"> City State ZIP Code Country </div>	
	5. What are your telephone numbers? <i>(Include Area Code)</i> Daytime _____ Evening _____	6. What is your e-mail address? <hr/>
SECTION II Tell us about your marriage NOTE: You should provide a copy of your marriage certificate	7. What is your marital status? <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <i>(If you are divorced, widowed or never married, skip to Section III)</i>	
	8. When were you married? <hr/> <div style="text-align: center; font-size: small;"> _____ mo day yr </div>	9. Where did you get married? <i>(city/state or country)</i> <hr/>
	10. What is your spouse's name? <hr/> <div style="display: flex; justify-content: space-between; font-size: small;"> First Middle Last </div>	
	11. When is your spouse's birthday? <hr/> <div style="text-align: center; font-size: small;"> _____ mo day yr </div>	12. What is your spouse's Social Security number? <hr/>
	13a. Is your spouse also a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," answer Item 13b also)</i>	13b. What is your spouse's VA file number <i>(If any)</i> ? <hr/>
	14. Do you live with your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "No," answer Items 15 through 17 also. If "Yes," skip to Section III.)</i>	
	15. What is your spouse's address? <hr/> <div style="display: flex; justify-content: space-between; font-size: small;"> Street address, Rural Route, or P.O. Box Apt. number </div> <hr/> <div style="display: flex; justify-content: space-between; font-size: small;"> City State ZIP Code Country </div>	
	16. Tell us why you are not living with your spouse.	17. How much do you contribute monthly to your spouse's support? <div style="text-align: center; font-size: large;">\$</div> <hr/>

SECTION III Tell us about any previous marriages

You must furnish complete information about **all** your and your present spouse's previous marriages. If you need additional space, please attach a separate sheet of paper providing the requested information about the marriages.

Your previous marriages

18a. How many times have you been married? _____

18b. Date of Marriage	18c. Place <i>(city/state or country)</i>	18d. To whom married <i>(first, middle initial, last name)</i>	18e. Date marriage ended	18f. Place <i>(city/state or country)</i>	18g. How marriage ended <i>(death, divorce)</i>
mo day yr			mo day yr		
mo day yr			mo day yr		

Your spouse's previous marriages

19a. How many times has your current spouse been married? _____

19b. Date of Marriage	19c. Place <i>(city/state or country)</i>	19d. To whom married <i>(first, middle initial, last name)</i>	19e. Date marriage ended	19f. Place <i>(city/state or country)</i>	19g. How marriage ended <i>(death, divorce)</i>
mo day yr			mo day yr		
mo day yr			mo day yr		

SECTION IV Tell us about your unmarried children

VA recognizes your biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:

- under age 18, or
- between 18 and 23 and pursuing an approved course of education, or
- of any age if they became permanently unable to support themselves before reaching age 18.

"Seriously disabled" (Item 21h) means that the child became permanently unable to support himself/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

If you need additional space, please attach a separate sheet of paper providing the requested information about each child.

Note: You should provide a copy of the public record of birth for each child or a copy of the court record of adoption for each adopted child.

20. Do you have any dependent children?

Yes No *(If "No," skip to Section V)*

SECTION IV Tell us about your unmarried children (continued)

21a. Name of child (First, middle initial, Last)	21b. Date and place of birth (City/State or Country)	21c. Social Security Number	21d. Biological	21e. Adopted	21f. Stepchild	21g. 18 - 23 yrs old and in school	21h. Seriously disabled	21i. Child previously married
	_____ mo day yr		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ mo day yr		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____ mo day yr		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tell us about the children listed above who don't live with you.

22a. Name of child (first, middle initial, last)	22b. Child's Complete Address	22c. Name of person the child lives with (if applicable)	22d. Monthly amount you contribute to child's support
			\$
			\$
			\$

**SECTION V
Tell us
about your
disability
and
background**

23a. What disability(ies) prevent you from working?	23b. When did the disability(ies) begin? _____ mo day yr
24. Are you claiming a special monthly pension because you need the regular assistance of another person, are blind, nearly blind, or having severe visual problems, or are housebound? <input type="checkbox"/> Yes <input type="checkbox"/> No	25a. Are you now, or have you recently been hospitalized or given outpatient or home-based care? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 25b and 25c also)
25b. Tell us the dates of the recent hospitalization or care. Began _____ mo day yr Ended _____ mo day yr	25c. What is the name and complete mailing address of the facility or doctor?
26a. Are you now employed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," answer Item 26b also)	26b. When did you last work? _____ mo day yr
26c. Were you self-employed before becoming totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Items 26d and 26e also)	26d. What kind of work did you do?
26e. Are you still self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer Item 26f also)	26f. What kind of work do you do now?

SECTION V Tell us about your disability and background (continued)

27a. Check the highest year of education you completed:

Grade school:

- 1 2 3 4 5 6 7 8 9 10 11 12

College:

- 1 2 3 4 Over 4

27b. List the other training or experience you have and any certificates that you hold.

SECTION VI Tell us your work history	In the table below, tell us about all of your employment, including self-employment, for one year before you became disabled to the present.				
28a. What was the name and address of your employer?	28b. What was your job title?	28c. When did your work begin?	28d. When did your work end?	28e. How many days were lost due to disability?	28f. What were your total annual earnings?
		mo day yr	mo day yr		\$
		mo day yr	mo day yr		\$
		mo day yr	mo day yr		\$

SECTION VII Tell us if you are in a nursing home To get your claim processed faster, provide a statement by an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability and tells us the amount you pay out-of-pocket for your care.	29a. Are you now in a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," answer Item 29b also)</i>	29b. What is the name and complete mailing address of the facility?
	29c. Does Medicaid cover all or part of your nursing home costs? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "No," answer Item 29d also)</i>	29d. Have you applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION VIII Tell us the net worth of you and your dependents

VA cannot pay you pension if your net worth is sizeable. Net worth is the market value of all interest and rights you have in any kind of property less any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal things you use everyday like your vehicle, clothing, and furniture. If property is owned jointly by yourself and your spouse, report one-half of the total value held jointly for each of you. You must report net worth for yourself and all persons for whom you are claiming benefits.

For Items 30a through 30f, provide the amounts. If none, write "0" or "None."

Source	Veteran	Spouse	Child(ren)		
			Name: (first, middle initial, last)	Name: (first, middle initial, last)	Name: (first, middle initial, last)
30a. Cash, bank accounts, certificates of deposit (CDs)					
30b. IRAs, Keogh Plans, etc.					
30c. Stocks, bonds, mutual funds					
30d. Value of business assets					
30e. Real property (not your home)					
30f. All other property					

SECTION IX Tell us about the income of you and your dependents

Payments from any source will be counted, unless the law says that they don't need to be counted. Report **all** income, and VA will determine any amount that does not count.

Report the total amounts before you take out deductions for taxes, insurance, etc. Do not report the same information in both tables. If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space. If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space. If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid.

31. Have you claimed or are you receiving disability benefits from the Social Security Administration (SSA)?

Yes No

SECTION IX Tell us about the income of you and your dependents (continued)

Monthly Income - Tell us the income you and your dependents receive every month

Sources of recurring monthly income	Veteran	Spouse	Child(ren)		
			Name: (first, middle initial, last)	Name: (first, middle initial, last)	Name: (first, middle initial, last)
32a. Social Security					
32b. U.S. Civil Service					
32c. U.S. Railroad Retirement					
32d. Military Retirement					
32e. Black Lung Benefits					
32f. Supplemental Security Income (SSI)/Public Assistance					
32g. Other income received monthly (Please write source below)					

Expected income for the next 12 months - Tell us about other income for you and your dependents

Sources of income for the next 12 months	Veteran	Spouse	Child(ren)		
			Name: (first, middle initial, last)	Name: (first, middle initial, last)	Name: (first, middle initial, last)
33a. Gross wages and salary					
33b. Total interest and dividends					
33c. Worker's compensation or unemployment compensation					
33d. Other income expected (Please write source below)					

SECTION X

Tell us about medical, legal or other unreimbursed expenses

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. If more space is needed attach a separate sheet.

34a. Amount paid by you	34b. Date Paid	34c. Purpose (Doctor's fees, hospital charges, attorney fees, etc.)	34d. Paid to (Name of doctor, hospital, pharmacy, etc.)	34e. Disability or relationship of person for whom expenses paid
\$	_____ mo day yr			
\$	_____ mo day yr			
\$	_____ mo day yr			
\$	_____ mo day yr			

SECTION XI

Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, "*All Federal payments...*" and then either:

1. Attach a voided check, or
2. Answer Items 35-37 to the right.

All Federal payments beginning January 2, 1999, must be made by electronic funds transfer (EFT) also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 35, 36 and 37 to enroll in Direct Deposit. If you do not have a bank account we will give you a waiver from Direct Deposit, just check the box below in Item 35. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

35. Account number (Please check the appropriate box and provide that account number, if applicable)

Checking

Savings

I certify that I **do not** have an account with a financial institution or certified payment agent

Account number _____

36. Name of financial institution

37. Routing or transit number

SECTION XII Give us your signature

1. Read the box that starts, "I certify and authorize the release of information:"
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have 2 people you know witness you as you sign. They must then sign the form and print their names and addresses also.

I certify and authorize the release of information:
 I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

38. Your signature	39. Today's date _____ mo day yr
--------------------	--

40a. Signature of witness (If claimant signed above using an "X")	40b. Printed name and address of witness
---	--

41a. Signature of witness (If claimant signed above using an "X")	41b. Printed name and address of witness
---	--

SECTION XIII

Remarks - Use this space for any additional statements that you would like to make concerning your application.

IMPORTANT

Penalty: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment which you are not entitled to.

42. Remarks *(If you need more space to answer a question or have a comment about a specific item number on this form please identify your answer or statement by the part and item number)*