

Department of State Health Services

# Recovery Manager Handbook

# RECOVERY MANAGER HANDBOOK

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## Roles and Responsibilities of Meeting with the HCBS-AMH Participant

*The section below provides tips on information to consider when meeting with the individual once you are assigned as their Recovery Manager.*

### Introduction to the Individual

#### **Preparation and Procedure**

The introductory meeting sets the tone for rapport building and successful future engagement. The primary goal is to begin building trust to enhance communication between the individual and the RM. Finding and exploring topics that demonstrate genuine interest builds rapport. The RM communicates respect for the individual, including his/her beliefs and goals.

Prior to meeting the individual and whenever possible, the RM should adequately prepare by consulting with existing clinical team members to learn the most successful methods for interacting with the individual.

For individuals residing in the hospital at time of enrollment in HCBS-AMH, a good starting point would be a meeting between the RM and social worker. It is helpful if the social worker or other clinical team member who has established rapport and trust with the individual can facilitate the introduction of the RM to the individual.

Further, contextual and environmental factors should be taken into consideration in order to facilitate a favorable initial interaction. Some factors to consider include:

- Time of day
- Location of the meeting
- Symptom profile (i.e. paranoia or disorganization)
- Symptom severity
- Individual's likes and interests
- Activities to facilitate rapport building

#### **Example**

The RM was asked to meet with a long term resident of the state hospital who was considered difficult to engage. Through collaboration with the social worker, the RM learned that the music therapist was most successful at engaging with the individual, and that the individual enjoyed discussions about classic rock. The RM accompanied

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the music therapist during her next visit and engaged the individual in discussion about music. In a subsequent visit, the RM brought a book on the history of one of the individual's favorite classic rock bands and they reviewed it together. Subsequently, the RM has met with the individual independently on multiple occasions, and has been able to explore numerous topics, including the individual's discharge into the community.



## Facilitating Engagement

Initial interactions with an individual will influence his/her level of engagement in the HCBS-AMH program and can affect positive treatment outcomes. Engagement is enhanced when an individual feels they are part of a therapeutic alliance that represents his/her interests and aspirations. The RM works to maintain rapport and trust while establishing a collaborative partnership. This creates a therapeutic alliance between the RM and the individual, thus creating the best opportunity for increased engagement in HCBS-AMH services. The RM acknowledges the expertise and knowledge that the individual brings as an essential part of their work together. The therapeutic alliance can be strengthened by highlighting how the expertise of the RM and the individual complement each other.

Some individuals may be more challenging to engage, particularly when they are identified as long term residents in the State Hospital. When working with an individual who is harder to engage, the process of developing rapport and establishing a therapeutic alliance takes longer, is accompanied by more barriers, and requires fine-tuned clinical skills and patience. It is not uncommon for an individual to be willing to engage one day, but not the next. It is helpful for the RM to focus on identifying ways to enhance engagement by exploring and establishing common ground with an individual. It is also helpful to take a non-confrontational and objective approach when exploring what is driving an individual to remain unengaged. Several possible factors to take into consideration are:

- Negative symptoms
- Past interactions with mental health professionals
- Beliefs regarding recovery potential
- Stigmatization
- Psychotic thought content
- Disorganization

Understanding what contributes to an individual's lack of engagement allows the RM to work with an individual and his/her clinical team to resolve issues limiting his/her participation in services.



## Addressing Changes in Behavior

As a result of his/her illness, some individuals display behaviors reflecting sudden escalation; they quickly become angry and agitated. This is important to remember when working with individuals and it is pertinent for the RM to monitor for signs of agitation in order to de-escalate a situation early, if possible.

Some techniques that have worked to manage these situations include:

- Exploring what is causing an individual's response. This needs to be done with care not to cause further escalation.
- A simple change in subject can be effective.
- It may be necessary to disengage and continue working with someone at another time.

There are many more techniques — the solutions are usually discovered as the RM continues to work with the individual and gets to know them better. When the techniques for de-escalation are exhausted or not successful, it can be helpful to utilize the Peer Support Specialist (PSS), who may play an integral role in aiding therapeutic alliance and engagement. When establishing a therapeutic alliance is limited, a PSS may be able to connect with an individual and establish trust that serves as a bridge between the individual and RM.



## Collaboration with the Clinical Team

### Interaction with the Clinical Team

When an individual is in the state hospital (SH), the HCBS-AMH SH liaison, which is the SH worker who is the point of contact for the HCBS-AMH program, is responsible for providing facility orientation and introducing the RM to members of the clinical team. Maintaining an open dialogue between the SH liaison and RM promotes collaboration and provides a healthy model for future interactions. The SH liaison can also be helpful in resolving conflicts and addressing concerns raised by the hospital or RM.

Prior to the initial meeting between the RM and the individual SH, the case is discussed with the individual's social worker. This meeting is a critical step to learn strategies that will help the RM develop trust and rapport with the individual, and begin developing the Individual Recovery Plan (IRP). Topics for this initial meeting may include:

- Relevant background and history
- Current social and/or family supports
- Individual's expressed wishes
- Treatment cooperation
- Individual's likes/dislikes
- Best methods for engaging

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Even though much of this information is available in an individual's records, the face-to-face meeting with the social worker should not be skipped. This interaction is valuable because the social worker is able to provide context and emphasize the most important information needed for planning and also provides insight regarding how to engage with individuals.

It is very important to have regular contact between RMs and social workers to promote ongoing collaboration. These ongoing updates ensure that vital information regarding the individual's progress is communicated first-hand. The frequency and length of updates should be determined on a case by case basis.

Over the course of the individual's enrollment in HCBS-AMH, the RM will need to work collaboratively with multiple members of the clinical team. This is determined by individual goals and may include:

- Psychiatrist
- Psychologist
- Medical Doctor
- Nursing Staff
- Nursing Assistance
- Occupational Therapist
- Art Therapist
- Music Therapist
- Activities Coordinator

Given the varied degree of knowledge and comfort level staff may have with the program, it is helpful to provide education on the program, Person Centered Recovery Planning (PCRP), and the role of the RM. It is essential to be considerate of staff concerns and answer any questions they may have.

## **Recovery Plan Meetings**

The RM is responsible for setting up and facilitating a recovery plan meeting to provide an opportunity for all parties, including the individual, to formulate a plan and reach consensus. Additionally, the meeting provides a collaborative framework where considerations from various team members and clinical perspectives can be taken into account. The following is information to consider when coordinating Recovery Plan Meetings:

- When an individual is residing in the state hospital, a minimum of three HCBS-AMH recovery plan meetings should be conducted during the transition phase of the program, with the option for more as needed;
- Initial meetings with RM and clinical team should include orientation to program and individual recovery planning;
- Individual Recovery Plan meetings should include the individual;

- Prepare for as needed meetings which will address any challenges or issues that may arise; and
- The pre-discharge meetings should include planning and coordination.

When the individual is present during the meeting—which is always preferable, comments and questions are first directed to the individual and are followed by a collaborative exchange between the individual and his/her clinical team. The plan is formulated by giving due consideration to the input of the individual and incorporating modifications when appropriate. In addition, the next steps are reviewed with the individual.

## Developing an Individual Recovery Plan (IRP)

### **Goal Setting and the Therapeutic Alliance**

For individuals with SMI, there are special considerations in maintaining the therapeutic alliance and engagement while generating and setting goals. Individuals dealing with SMI may have difficulty generating reasonable goals or expectations, thus providing an early opportunity to introduce conflict into the therapeutic relationship with the RM. It is neither helpful nor useful to dismiss an individual's expectations or goals because they are unreasonable: avoid getting into a power struggle. It is more effective to learn why the individual has chosen each particular goal and determine what is important to the individual about his/her goals and expectations. Engaging the individual in this way acknowledges respect for his/her wishes, and can lead an individual to be more open to a discussion about goals. The RM may also explore alternative or backup plans with an individual. This has the benefit of developing a plan for a mutually agreed upon goal without directly confronting an unreasonable goal. The RM is, in essence, asking for another acceptable alternative without requiring the individual to sacrifice his/her stated goal.

### **Example**

Many individuals want to leave the hospital and move into their own home or apartment. They may be adamant that they do not need supervision or assistance. In contrast, there is a consensus among his/her clinical teams that they need to transition into an environment with some degree of supervision and structure. This situation introduces a gulf that needs to be bridged between the RM and the individual. In one case, discussing the individual's attitudes and beliefs about accepting assistance and "charity" led to an agreement that some forms of assistance were acceptable. Had the RM simply stated that there was no option for her to live in her own home, this would have shut down the process of communication, and resulted in an impasse. Instead, exploring her attitudes and beliefs kept open the lines of communication and allowed for a shift in attitude.

This example illustrates that generating realistic goals is a process that sometimes requires incremental steps that cannot be accomplished in one meeting. The goals of individuals with SMI may be at odds with the recommendations of their clinical team. This poses a challenge for the RM to navigate while maintaining a person centered

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recovery perspective. If an individual sees his/her RM as an ally working for his/her best interests, they may be more amenable to feedback and modification of his/her goals. This once again emphasizes the importance of building a therapeutic alliance as the IRP is a central component of the pre-transition work in the HCBS-AMH program.

## **Realistic Goal Setting**

Realistic goal setting provides an opportunity to create successful experiences for an individual that can enhance his/her engagement, self-confidence, and hopefulness. Realistic goals are short-term and achievable, even if supports are needed to complete them. The individual and RM collaboratively identify specific areas for goal setting. These may include:

- Housing
- Employment
- Social interaction
- Education
- Benefits and services
- Health and wellness
- Daily activities
- Recreation and leisure

The phase of goal development is where potential conflict is most likely to occur. Often individuals will generate goals that reflect his/her wishes, but they do not consider practical limitations or the steps necessary to reach the goals. Under these circumstances, the RM needs to explore the step-by-step processes involved in achieving a goal alongside the individual. This process should not directly challenge the goal, but together the RM and individual can explore the manner and likelihood of attaining a goal. Not all individuals have the capacity to engage in this step-by-step conversation, thus making other visual, mnemonic, and organizational aids helpful. For long-term goals it is helpful to break the goal down into a series of steps that serve as short-term goals which provide incremental progress.

## Providing Transition Services

*The section below outlines RM responsibilities when providing Transition Services to HCBS-AMH participants in the state hospital or another HCBS program.*

## Credentialing

### **Recovery Manager Credentialing**

Prior to the initial meeting with the individual for transition services in the state hospital, RM must complete the following credentialing process: (See 13620 Credentialing for Service Provision within the State Hospitals of the HCBS-AMH Provider Manual)

- RM receives credentialing form from HCBS-AMH staff via email.
- RM sends email to HCBS-AMH staff with subject line: “Date of Fingerprinting and Copy of Credentials.” This email will include the following:
  - Date of fingerprinting appointment
  - Copy of degree, licensure, or certification
- RM receives email from HCBS-AMH staff verifying completion of the credentialing process and approval date to start HCBS-AMH transition services.

### **Assisting Providers with Credentialing**

RM is responsible for assisting identified HCBS-AMH providers with completing the credentialing process before they provide transition services in the state hospital.

- RM notifies selected providers and obtains copies of their degrees, licensure, or certifications.
- RM sends email to HCBS-AMH staff with subject line “Selected HCBS-AMH providers.” This email should include the following:
  - Provider Selection Form
  - Name of selected providers
  - Copy of selected providers’ degree, licensure, or certification

- RM receives credentialing forms from HCBS-AMH staff to be completed by providers.
- RM provides forms to HCBS-AMH providers.
- RM receives email from HCBS-AMH staff verifying completion of the credentialing process and approval date for providers to start HCBS-AMH transition services in the state hospital.
- RM notifies providers of approval date and coordinates first recovery plan meeting with providers.

## Transitional Services

*\* Please note: Transitional services for the individual in the state hospital vary from 3 to 6 months. In certain cases, it will be necessary to start the discharge planning process earlier than four to six months.*



### **The First Month of Transitional Service Identify the Type of Housing Needed**

The type of housing an HCBS-AMH participant relocates to upon leaving the hospital is perhaps the most essential component of an individual's IRP. Determining the level of supervision required in the community to increase the potential of an individual's success is the essential piece that determines this type of housing. It is important for the clinical team, hospital staff, and the individual to agree on this type of housing before moving forward with housing applications (due to different requirements for various options).

### **Example**

If an individual is moving into a Type A or B Assisted Living Facility, it is possible they will not need his/her birth certificate or social security card. If they are moving into an apartment with a housing voucher, then they will need multiple documents for identification along with a background check. In all instances they will need income.

Finding a balance between the individual's preference and the recommendation of the clinical team can take some time. It is frequently a lack of agreement on housing that can keep the process of an individual relocating into the community from moving forward. In one case, an individual was insistent that they move into a trailer on some land in a rural area with limited services and the RM and hospital staff felt appropriate housing would be a small assisted living facility or group home. Over a process of two months the client agreed to move into more of a group home setting. Continual reengagement with the individual was required to keep the conversation going and the door open for options.

## **Start Early on Documents**

One of the greatest barriers to transitioning individuals out of institutions into housing can be obtaining the basic documents such as a current ID, certified copy of a birth certificate, and a social security card. It can be a time consuming, frustrating process for both the individual and those assisting the individual. This can hold up an individual from even getting on the wait list at certain properties or for certain types of housing vouchers. In a six-month time line for transition services, the documents need to be obtained as quickly as possible.

Efficiency and creativity can be an asset in this process. Here are some tips:

- The Department of Public Safety (DPS) can come to the state hospital to issue a Texas ID rather than taking an individual to the DPS office (this is called a Homebound Request).
- At the DPS office, individuals with disabilities can be fast-tracked upon entry and often have a wait less than fifteen minutes.
- The state hospital has a point of contact to work with the social security office to assist an individual in either restarting his/her SSI or SSDI if it was suspended or in applying for SSI.
- DSHS has executed a SSA Pre-release agreement. This allows individuals being discharged from the hospital, to begin their application for SSA benefits 90 days prior to discharge.
- An individual having difficulty obtaining necessary documents for a housing voucher can request a reasonable accommodation from a property or housing authority. For example, if an individual has his/her social security card and a current ID, but they are unable to obtain his/her birth certificate due to extraordinary circumstances, an accommodation can be requested. There is no guarantee this will be granted, but it can certainly be requested.

## **Anticipate Housing Barriers**

This is most applicable for HCBS-AMH participants relocating into an apartment setting whether it is supportive housing, permanent supportive housing, or just a standard fair market apartment in the community. Common barriers for someone that has been in a state hospital for an extended period of time are:

- Bad credit
- Broken leases
- A criminal history

These are all issues that can cause a property owner/manager to deny a rental application. When someone is denied at a property or for a housing voucher here are steps that you can take to advocate for the individual:

- Request a reasonable accommodation for previous credit issues, evictions, or criminal history

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- If the issues are tied to the individual's disability (mental illness) as they often are related, Austin Tenant's Council provides a helpful packet on how to request a reasonable accommodation with an example of a letter ([http://www.housing-rights.org/PDF/forms/RA\\_RM\\_Packet.pdf](http://www.housing-rights.org/PDF/forms/RA_RM_Packet.pdf))
- Advocate for the individual's acceptance at a property and explain the support services that the individual will have in his/her home. (a sample advocacy letter is attached)
- Consult and collaborate with the local Legal Aid office or Disability Rights of Texas. They can assist in this type of advocacy. Try to identify what barriers might already exist for an individual and anticipate what type of advocacy might be needed before applying for housing.

## **Engage Informal Supports**

Assessing the type and level of support loved ones and friends have the capacity to provide is an important component of painting a realistic picture of what life might be like for the individual upon relocation. This most often happens due to the need for information regarding an individual's documents, income, or obtaining consent if there is a Legally Authorized Representative (LAR). It is important to separate desire to give support from the actual capacity someone has to give support. Resistance and trepidation is a common and understandable response from loved ones. They know their spouse, child, or sibling is safe right now in the hospital. They are keenly aware of all the times their loved one tried to discharge from the hospital and it ended with another hospital readmission. This is their loved one and that relationship and the perceived or real burden of that responsibility in the community must be respected. Identifying people and groups in an individual's life that will be present once they are in the community can be an essential component of someone's path toward recovery in the community. Taking the time to listen to the concerns a loved one expresses and problem-solving in a direct way can not only alleviate some of the fear a loved one may have about an individual relocating into the community, but also begin the process of building a supportive environment for the individual that is focused on recovery.

## **Coordinating with Selected HCBS-AMH Providers**

The RM is the point of contact for all HCBS-AMH service providers. The RM is responsible for initiating, coordinating, and monitoring all HCBS-AMH services the individual receives while in the HCBS-AMH program. Below, are a few tips to consider to help the coordination of care run smoothly:

- **Convene a Group Meeting.** Get the key players from each of the selected HCBS-AMH providers for a recovery plan meeting. If it's not possible for everyone to be together, use Skype or video conferencing so everyone can see each other. Keep the atmosphere upbeat and set a deliberate tone of collaboration.

- **Establish clear, realistic, and measurable goals for the overall plan for the meeting.** Encourage the input of everyone at the table and before the goals are solidified, ensure you have buy-in from each provider.
- **Clarify the roles and deliverables for each HCBS-AMH provider.** Examine potential overlaps / potential gaps between roles.
- **Identify a point of contact at each HCBS-AMH provider and develop a communication protocol.** Create a communications distribution list. Figure out what information needs to be shared with the group and what requires limited sharing. Copy everyone on the email and phone list. Ensure emails are sent through a secure encrypted email.
- **Hold Regular Meetings.** Set up regular meetings weekly to review progress and make adjustments as necessary. Group calls are fine, but meet in person as much as possible.
- **Celebrate the successes!** All providers like to be told when they are doing a great job. It is all the better if the positive outcomes are the result of your provider working together. Praise the collaboration and build on each success.

## **The Second Month of Transitional Services**

### **Ascertain Services Needed in the Community**

Anticipating what life will be like in the community for an individual that has been institutionalized for years will guide the types of pre-transition services and community services the individual needs upon relocation. The key is to identify the skills that can be bolstered while the individual is still in the hospital versus what adaptations will be necessary once they transition to the community.

### **Example**

If an RM works with someone in the first month and determines that they are not able to budget and likely not to gain these skills during the transition time frame, the RM would want to assist the individual in obtaining a representative payee upon discharge into the community.

Here are some tips that will help an individual prepare to transition into the community:

- Discuss, in-depth, what past community living was like for this individual. Be extremely curious about what worked for them and what did not work for them.
- Visualize them doing everyday things like picking up his/her mail, doing his/her laundry, or grocery shopping. Have they done these before? What helped them?

- Visualize the individual building relationships and identify the strengths, resources, and challenges envisioned with these tasks. What types of relationships have they maintained in the past?
- Can you imagine this individual paying a bill, navigating the internet, or using public transportation?
- If it is unclear how well an individual can complete a task, role play the task with him/her. This can be extremely helpful to assess if someone can
  - Pay a bill
  - Understand a monthly budget
  - Set-up a medication box
  - Make an appointment with a doctor

### **The Third Month of Transitional Services**

#### **Use the Housing Process to Build an Alliance with the Individual**

No matter the amount of knowledge and expertise the RM and hospital staff have, there is a large amount of the housing process that is simply out of their control. It is likely that the individual and the RM will become frustrated with the process of locating the best living situation with the best possible services. It is possible to use this situation, if appropriate, to further the alliance with the individual. If he or she sees the frustration the RM experiences, there is a sense that “we are in this together.”

### **Four to Six Months of Transitional Services**

#### **Coordinating with HCBS-AMH Providers Prior to Discharge**

One month prior to discharge, RM is responsible for identifying necessary HCBS-AMH services the individual will need after his/her discharge from the hospital. RM assists the individual in identifying HCBS-AMH services and HCBS-AMH providers. Once these HCBS-AMH providers are identified, RM will coordinate a recovery plan meeting.

#### **Recovery Plan Meeting Prior to Discharge**

Two weeks before discharge, a recovery plan meeting should be held to complete an updated IRP with the RM, hospital staff, clinical team, and selected HCBS-AMH providers. This meeting is essential to update the IRP, identify the service providers in the community that will be used for specific supports required, and make sure all aspects of the transition have been covered.

#### **Coordinating with Managed Care Organization (MCO) STAR + PLUS**

Most HCBS-AMH participants will be enrolled in STAR + PLUS MCO for acute care services. RM is responsible for coordinating with the individual’s identified MCO service coordinator, if one has been identified, prior to the individual’s discharge from the state hospital. It is the expectation the RM will ensure the MCO service coordinator is involved in the updated IRP planning process either in person or via conference call.

## Transitioning an Individual from another HCBS Program



### **HCBS Programs**

Some individuals determined eligible for the HCBS-AMH program, maybe enrolled in another HCBS program and choose to disenroll from his/her current HCBS program into the HCBS-AMH program. The individual maybe enrolled in the following HCBS programs:

- Long-term Services and Supports (LTSS);
- Community Living Assistance and Support Services (CLASS);
- Deaf Blind with Multiple Disabilities (DBMD);
- Home and Community-based Services Waiver (HCS);
- Texas Home Living Waiver (TxHml); or
- STAR+PLUS HCBS Waiver

If an individual decides to disenroll from his/her current HCBS program and enroll into HCBS-AMH, the RM will provide RM conversion services to the individual during the individual's enrollment/disenrollment process.

### **Preauthorization**

In order to provide RM conversion services, the RM must obtain preauthorization. Preauthorization is approval by HCBS-AMH staff for coverage of recovery management services prior to the individual's enrollment in HCBS-AMH. RM conversion services are the only services eligible for preauthorization.

### **Obtaining Preauthorization**

Preauthorization of RM services will allow the RM to work with the individual's HCBS team to ensure a smooth transition into the HCBS-AMH program. The following information is necessary to consider when transitioning an individual into HCBS-AMH.

- The necessary preauthorization paperwork must be completed before RM conversion services can start.
- HCBS-AMH participant will receive one month of conversion services.
- RM conversion services will begin the first of the month following the approval by HCBS-AMH staff of preauthorizes of RM conversion services.
- Enrollment into HCBS-AMH will begin the first of the month following the month of RM conversion services

### **Coordinating with HCBS Providers**

RM will be the point of contact for the HCBS providers of the program from which the individual is disenrolling. RM should consider the following information when coordinating with HCBS providers:

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- It is important for RM to identify a point of contact at each of the HCBS provider agency.
- RM should use that point of contact to obtain all pertinent information on the individual and the services they have received in his/her current HCBS program.
- RM should facilitate weekly conference calls with the HCBS providers to discuss coordination of services and any barriers that may arise during the transition process.
- Some housing provided to the individual is tied solely with the HCBS program in which the individual is currently enrolled. Therefore, if an individual is transitioning to the HCBS-AMH program, they may need to find alternate housing.
- If alternate housing needs to be secured, the RM should start identifying alternate housing alternatives as early as possible to ensure the housing will be available at the start date of HCBS-AMH services.
- RM should work in collaboration with the HCBS providers and utilize housing resources they may have available, if applicable.
- RM will likely need to meet with the individual three times per week. RM will assist the individual in selecting HCBS-AMH providers.
- Once HCBS-AMH providers have been selected, RM is responsible for sending all pertinent information on the individual to the selected HCBS-AMH providers.

## **Coordinating with HCBS – AMH Staff**

RM should utilize DSHS HCBS-AMH staff while providing RM conversion services. RM should communicate with HCBS-AMH staff in the following situations:

- RM should reach out to HCBS-AMH staff if there are any delays in obtaining an individual's information from current HCBS providers.
- RM should notify HCBS-AMH staff and HCBS providers of any delays in transitioning the individual.

## Resources Available to the HCBS-AMH Participant

*The section below provides information on available housing resources as well as resources available for the indigent population.*

### Housing Programs

#### **The Housing Referral Process**

The RM is responsible for referring HCBS-AMH participants to housing programs. Throughout the referral process, the RM will be the main point of contact for housing providers. Below are the responsibilities of the RM during the housing referral process:

- RM will be responsible for assisting individual with completing their housing application, if applicable, for housing options available to the individual
- RM will be responsible in obtaining any supporting documents necessary to complete the application.
- RM will submit the application to Texas Department of Housing and Community Affairs (TDHCA) and follow up with TDHCA bimonthly regarding the status of application.
- RM will outreach to landlords and property owners to assist individual with securing housing.

Below, is a summary of two housing programs in which HCBS-AMH participants will be eligible.

#### **Section 811**

The Section 811 Project Rental Assistance (PRA) Program creates affordable housing, through project based rental assistance, for extremely low-income persons with disabilities linked with long term services through a partnership between the TDHCA, and the State Medicaid Agency, the Texas Health and Human Services Commission (HHSC.) The following populations are eligible:

- **People with disabilities living in institutions.** People that wish to transition to the community from nursing facilities and intermediate care facilities for persons with intellectual disabilities may not have access to affordable housing in their community.

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- **People with serious mental illness.** These individuals are engaged in services but face challenges due to housing instability. Stable, integrated, affordable housing would enable these individuals to have the opportunity to fully engage in rehabilitation and treatment, greatly improving their prospects for realizing their full potential in the community.

**For the most up to date information on the Section 811 program, see**

[www.tdhca.state.tx.us/section-811-pra/index.htm](http://www.tdhca.state.tx.us/section-811-pra/index.htm)

## **Project Access**

The Project Access program utilizes Section 8 Housing Choice Vouchers administered by TDHCA to assist low-income persons with disabilities in transitioning from institutions into the community by providing access to affordable housing. The following populations are eligible:

- Have a permanent disability as defined in Section 223 of the Social Security Code or be determined to have a physical, mental or emotional disability that is expected to be of long-continued and indefinite duration that impedes one's ability to live independently;
- Meet one of the following criteria:
  - Be an "At-Risk Applicant" and a previous resident of a nursing facility, intermediate care facility, Texas state psychiatric hospitals, or board and care facility as defined by the U.S. Department of Housing and Urban Development; or
  - Be a current resident of a nursing facility, intermediate care facility, Texas state psychiatric hospitals or board and care facility at the time of voucher issuance as defined by the U.S. Department of Housing and Urban Development; or
  - Be eligible for a pilot program with the Department of State Health Services (DSHS) for residents of Texas state psychiatric hospitals

**For the most up to date information on Project Access, see**

[www.tdhca.state.tx.us/section-8/project-access/index.htm](http://www.tdhca.state.tx.us/section-8/project-access/index.htm)

## **Other Housing Resources**

### **2-1-1 Texas**

The 2-1-1 Texas website offers a wealth of public assistance referrals for Texans searching for support services. The "Housing and Shelter Services in Texas" page offers:

- Emergency shelter assistance:
  - Homeless shelters;

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- Runaway/youth shelters;
- Domestic violence shelters;
- Sexual assault shelters;
- Subsidized housing services:
  - Public housing;
  - Section 8 Housing Choice vouchers;
  - Section 8 Rental listings;
  - Sweat equity programs;
- Supportive housing:
  - Long term care providers;
  - Assisted living facilities
- Housing expense assistance:
  - Rent payment;
  - Rental deposit;
  - Mortgage payment assistance;
  - House down payment assistance;
- Affordable housing assistance:
  - Low-income housing;
  - Housing search assistance;
  - Alcohol recovery halfway houses;
  - Substance abuse recovery halfway houses;
  - Ex-offender halfway houses;
- Home improvement, accessibility services:
  - Home repair;
  - Home accessibility;
  - Ramp construction; and
  - Weatherization programs

2-1-1 Texas is a program of the Texas Health and Human Services Commission, and is committed to helping Texas citizens connect with the services they need. For information on these programs, go to <https://www.211texas.org/cms/search-housing-shelter-services-in-texas> or just dial 211.

## Advocacy in Housing

### **Eviction and Fair Housing Concerns**

For resources on eviction relief, visit <http://www.tdhca.state.tx.us/texans.htm> and <http://texaslawhelp.org/issues/housing/eviction>

For more information on Fair Housing, visit <http://www.tdhca.state.tx.us/fair-housing/renters.htm>

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## **Working with the Public Housing Authority**

Developing a strong relationship with the Public Housing Authority in the individual's area of residence, can be a key component in helping the HCBS-AMH participant obtain safe and affordable housing.

The Substance Abuse and Mental Health Service Administration (SAMHSA) conducts regular webinars on how to effectively work with public housing authorities. For a schedule of these webinars, visit

[http://usich.gov/about\\_us/funding\\_programs/calendar/samhsa\\_webinar\\_working\\_with\\_public\\_housing\\_authorities](http://usich.gov/about_us/funding_programs/calendar/samhsa_webinar_working_with_public_housing_authorities)

## Resources for the Indigent Population

### **Organizations that Provide Assistance**

RM is responsible to assisting indigent individual in accessing services.

Below, are some of the resources available to the indigent population:

- County Indigent Health Care Program
- Catholic Charities
- Capital Area Food Bank
- Caritas of Austin, Inc.
- Legal Aid for the Homeless
- Neighborhood Center Services
- Texas Rio Grande Legal Aid
- Homeward Bound Inc.

### **Trainings**

The following trainings are available to assist with providing services to the indigent population:

- SOAR
  - Provides training on how to assist disabled individuals who are experiencing homelessness.
- Certified Application Counselor
  - Provides training Assist eligible individuals apply for insurance on the Health Exchange
- County Indigent Health Care training
  - Provides training about resources available in the community for indigent population

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