Third-Party Verification of Homelessness for Eligibility Determination

Summer 2018

The purpose of the Health Care for the Homeless (HCH) program, according to 1999 guidance from the Health Resources & Services Administration (HRSA), is "to improve the health status and outcome of care for homeless individuals and families by improving access to primary health care and substance-abuse services" (PAL99-12). As the letter itself acknowledges, this charge is profound, not just because of the substantial barriers that preclude people experiencing homelessness from accessing traditional medical care, but because the health of these patients is far worse than that of the general population. Health center leaders would add to the list of difficulties the challenge of patients' common inability to pay for services—health centers are compelled to maximize revenue in order to accomplish their organizational missions, and serving people experiencing homelessness, who are disproportionately underinsured, can strain resources. In this context, health centers specifically funded to serve people without homes (through the HCH program) must ensure their federally funded services are dedicated to the program's intended audience.

> **Read this, too:**
> *Verifying* homelessness differs from *documenting* homelessness. All health care agencies should be assessing the housing status of all their patients and recording it. Learn more in *Ask & Code: Documenting Homelessness Throughout the Health Care System.*

The National Health Care for the Homeless Council provides technical assistance (TA) to health centers on behalf of HRSA, the agency that also funds the health center program. In our work through this National Cooperative Agreement, one of the most common topics for TA pertains to eligibility for services and the sometimes-related Sliding Fee Discount program. In particular, HCH health centers often query the Council for the best approaches to verifying that their prospective patients are indeed experiencing homelessness.

This resource is meant to identify the regulatory issues affecting health centers' eligibility determination, with a focus on third-party verification, and to supply a range of practices utilized by HCH health centers across the country whose policies and practices comply with their respective audits and operational site visits. The Council does not advance a particular approach, but rather seeks to illuminate the range of permissible options.

Regulatory Requirements

Through Circular A-133 of 1990, the Office of Management and Budget extended the Single Audit process to include nonprofit organizations that receive more than $750,000 of federal funding per year.[1] The purpose of this audit is to ensure that organizations receiving federal funding use those funds in the manner in which they were intended. This bears upon health

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[1] https://web.archive.org/web/20070618061015/http://www.whitehouse.gov/omb/financial/fin_single_audit.html

centers in that their policies must be justified with documentation denoting their federally funded services were provided exclusively for the patients within the target population. In the context of HCH, beneficiaries of 330(h) dollars must be people who meeting the HHS definition of homelessness. For general-population Community Health Centers (330e), this would seem less onerous because they are funded to serve patients of all kinds; their funding is not restricted to a particular population, so if a patient's homelessness cannot be verified, they are compelled to serve that patient anyway. For special-populations-only health centers (i.e. health centers that exclusively serve people experiencing homelessness and/or residents of public housing and agricultural workers: sections 330(h), 330(i), and 330(g), respectively), this necessitates they demonstrate that no less than 75% of their patients represent the population their health center grant supports them to serve (see PIN 2009-05). In other words, HRSA allows such health centers to serve up to 25% of their patients who are outside their target population, presumably accounting for the thin line between precariously housed individuals and those within the official definition.

While the A-133 audit requires that health centers employ systems of verifying eligibility for services, it does not require *third-party* verification. In fact, for numerous Health Care for the Homeless programs, self-attestation is sufficient verification of housing status. For many, patients encountered on the streets or in other non-clinical locations such as shelters are presumed homeless. Such policies are deemed compliant by their respective auditors and Operational Site Visit (OSV) reviewers. Moreover, public entity HCH health centers (which are disproportionately represented among HCH programs), operate under even more intense scrutiny as public institutions (usually city or county health departments), yet their eligibility polices are often the broadest. In addition, while the Council's experience is that jointly funded Community Health Centers are more likely than HCH standalones to require third-party documentation, many do rely solely on self-declaration for assessing homeless status. It is clear, therefore, that numerous auditors allow for self-attestation as sufficient assurance for proper use of federal funds. Refer to the Program Profiles below for examples of such strategies.

> **The Health Center Compliance Manual's Definition of Homelessness**
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> Individuals:
> • Who lack housing (without regard to whether the individual is a member of a family);
>
> • Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations;
>
> • Who reside in transitional housing; and/or
>
> • Who reside in permanent supportive housing or other housing programs that are targeted to homeless populations.*

With regard to HRSA's requirements, a careful review of the Health Center Program Compliance Manual[2] of 2017 (including the still-active policy resources it lists in Appendix A) reveals no regulation on verification of homelessness. Perhaps the most similar mention in the Compliance Manual pertains to the Sliding Fee Discount program (Chapter 9), which may elicit some

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[2] https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf
* Revisions to the Health Center Compliance Manual announced August 21, 2018, add new categories: a health center "may also serve children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness." (p. 89)

confusion in the field. Key requirements include that health centers "must operate in a manner such that no patient shall be denied service due to an individual's inability to pay." (p. 37) Moreover, health centers must have established fees for their services "designed to cover reasonable cost of operation and must prepare a corresponding schedule of discounts [sliding fee discount schedule (SFDS)]." The Manual later specifies that a health center's Board-approved policy for determining eligibility for the SFDS must be assessed "based *only* on income and family size." (p. 38, emphasis added) As a "related consideration," however, it continues:

*The health center determines whether to take into consideration the characteristics of its patient population when developing definitions for income and family size and procedures for assessing patient eligibility for SFDS. For example, the health center may consider the **availability of income documentation for individuals experiencing homelessness**, build in cost of living considerations when calculating income, **permit self-declaration** of income and family size.* (p. 41, emphasis added)

As corroborated by the Council's experience in providing technical assistance for thirty years, this corresponds with numerous HCH health centers' Sliding Fee Discount policies that consider homelessness justification to either slide to zero or withhold a nominal fee. While homelessness is fundamentally a housing status, not an income measurement, these policies pass muster at their respective organizations, which usually enable them to provide care at no cost to their patients without homes. Health centers have discretion in developing eligibility policies that account for the unique context of homelessness within their patient population.

Finally, the Uniform Data System (UDS) requirements may serve as an additional source of regulatory influence on health centers' eligibility policy development. While all health centers report their total number of homeless patients in their annual UDS report, HCH grantees must specify the shelter arrangements of their patients experiencing homelessness in six categories: shelter, transitional housing, doubled-up, street, other, and unknown[3] (p. 44). That these data are required reporting fields may suggest to health centers that they must verify these shelter arrangements, though UDS guidance makes no such mention.

Considerations in Planning Your Approach

Although third-party verification is not required for the HCH program, consider the following perspectives if your health center is in the position of developing or evaluating its policies for verifying the homeless status of its patients.

Rationale in favor of third-party verification:

> ## Key Takeaways:
>
> 1. You need a policy that governs Eligibility for Services, per OMB A-133, in addition to Eligibility for the Sliding Fee Discount Schedule.
>
> 2. HRSA does not require third-party verification of homelessness.
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> 3. Be mindful of other funders or referral programs that may require stricter policies.
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> 4. Approaches to patient eligibility should be low-barrier and trauma-informed.

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[3] https://bphc.hrsa.gov/datareporting/reporting/2018-uds-reporting-manual.pdf

- **It ensures proper use of funds**
  Health centers are highly regulated nonprofit organizations who must continually adhere to the compliance standards of federal, state, and local-government funders, in addition to private donors. Third-party verification can be an effective tool for assuring auditors and funders that your services are implemented as prescribed.
- **Other homeless services may require it**
  Health Care for the Homeless health centers are often integral in local efforts to reduce and end homelessness, and they seldom operate outside of coalitions. Other service providers may utilize more stringent eligibility criteria, such as agencies funded by the department of Housing and Urban Development (HUD), which exercises a narrower definition of homelessness. In order to make proper referrals to community partners, third-party verification may be necessary.
- **It may help to optimize scarce resources**
  Health centers must maximize all available funding streams, just like any nonprofit agency. With limited resources, stricter protocol for assessing services eligibility may decrease uncompensated health care costs, since the homeless population is largely underinsured.

Rationale against third-party verification:

- **It may be a barrier to care**
  In general, any documentation is difficult for people experiencing homelessness to retain. Living in places not met for human habitation means personal belongings, including paperwork, are subject to loss or theft. Policies that leave to patients the responsibility of acquiring third-party signatures may dissuade them from accessing care.
- **It can hinder meeting patient projections**
  While it is true that health centers must cut unnecessary costs, they must also see as many patients as they projected in their grant application. Failure to meet patient projections may result in funding cuts from HRSA.[4] If a health center is struggling to meet its targets and avoid cuts to the base grant, eliminating third-party verification may help by ensuring they are not turning away eligible patients.
- **It can consume staff time**
  Depending on your staffing arrangement, the effort for registration workers or case managers to acquire third-party homeless status documentation can consume valuable time. Avoiding third-party verification may improve your frontline staff's productivity.

General Recommendations

It is incumbent on health centers to use their 330 grants as prescribed, especially in light of perpetually scare resources. Because third-party verification is not a required HRSA practice, the first step is to educate board and staff. This may ultimately have no impact on one's processes, but it is important to have accurate knowledge of the parameters and all possible approaches. Health centers should take into account their other funding requirements, staff capacity, and

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[4] Guidance from HRSA delineates a scale for reducing the base grant according to patient target shortcomings: https://bphc.hrsa.gov/programopportunities/fundingopportunities/sac/patienttargetfaq.pdf

registration workflow to consider whether third-party verification is helping or hindering their ability to achieve their mission.

Perhaps more importantly, this question should be put to health centers' homeless consumers. Through whichever mechanism by which they obtain patient feedback (e.g. consumer Board members, Consumer Advisory Boards, focus groups, patient surveys, etc.), they should assess whether third-party verification is perceived as an obstacle to accessing care. Consumers' insight as users of health center services is critical to ensuring patient-centered care, which is the ethic behind the consumer-majority Board that distinguishes community health centers from other nonprofits.

Additionally, while the Council recognizes the diversity of contexts to which HCH grantees belong, we generally recommend that eligibility policies reflect the breadth of the HHS definition of homelessness, including those who are "doubled-up" or residents of permanent supportive housing. While other government agencies use more restrictive criteria to define homelessness, the 330(h) program was uniquely designed to recognize *housing instability* as the crucial indicator (see PAL 99-12), which positions HCH grantees to serve a diverse range of highly vulnerable people.

Finally, whether health centers require third-party documentation for every patient, rely solely on self-attestation, or a combination, a trauma-informed and culturally sensitive approach is paramount. People without homes must navigate a complex system of care while also attending to their short-term survival needs, often in the midst of mental illness or addiction. Procedures of engaging new patients should unfailingly recognize the tragedy that is homelessness and poverty, and a health center may be the only opportunity for them to feel respected and safe.

Program Profiles

Standalone HCH Health Centers: 330(h) only

Seattle-King County Health Care for the Homeless Network: Seattle, WA
A public entity health center, Public Health- Seattle & King County leads the 10-agency HCH Network (HCHN), providing clinical services itself and contracting with an array of primary care, behavioral health, and other health care providers. When HCHN witnessed a decrease in unduplicated patients, which threatened funding cuts, it identified two main causes: reporting challenges related to transitions from paper to electronic health records systems and inconsistency in intake procedures for identifying patients meeting the HHS definition for homelessness. HCHN created a comprehensive training program for front desk staff responsible for screening for homelessness and entering homeless status into the EHR, which contributed to its homeless patient numbers climbing back up to prior levels. Its ongoing endeavor to ensure accurate screening informs their avoidance of third-party verification.

Duffy Health Center: Cape Cod, MA
Based in Hyannis, Duffy Health Center serves people without homes in Cape Cod, approximately half of whom are doubled-up. Adhering closely to the aforementioned 25% rule, Duffy's eligibility policy comprises four categories. The first two categories include people who meet the HHS definition of homelessness (with about twenty categories of shelter arrangements in their registration forms) and those who are unstably housed, whom they include in their target

population and the 75%. The third category includes those who are at risk or not homeless but have a need that Duffy can meet such as treatment for opioid addiction. The fourth category of individuals are not eligible for Duffy services, which usually comprises people with commercial insurance, which Duffy does not bill. Homelessness is determined by self-report.

Care for the Homeless: New York, NY
One of the largest standalone Health Care for the Homeless grantees in the country, Care for the Homeless operates a network of clinics based in shelters and soup kitchens. Because a vast majority of patient encounters take place where people experiencing homelessness congregate, CFH hardly has concern that they will exceed the 25% threshold. Therefore, CFH does not use any third-party verification of housing status, but it does screen for shelter arrangements per the UDS measures.

Mercy Medical Center Health Care for the Homeless: Springfield, MA
The Health Care for the Homeless program in Springfield is a collaborative effort between the city government and a Catholic hospital: the Springfield health department is the grantee, but the services are carried out by staff of Mercy Medical Center at numerous sites. Patients seen at shelters or the Salvation Army and Rescue Missions are presumed eligible. Patients who visit the brick-and-mortar site are asked for any change of address at every visit, but self-report almost always suffices. In their practice, patients are assessed for their housing status according to the UDS categories and other shelter arrangements, but third-party verification is only obtained when attempting to enroll patients in other benefits, such as the region's housing program for chronically homeless individuals or state and federal cash assistance programs.

Community Health Centers with HCH Funding: 330(e) + (h)

Southwest Community Health Center: Bridgeport, CT
Southwest CHC's McKinney Homeless Health Care provides services to homeless patients at any of five main locations, in addition to seven school-based sites and six shelters where Southwest CHC maintains licensed exam rooms. Their participation in many community events facilitates outreach to homeless persons who would like to access services. It uses a traditional registration form for new patients, coupled with a personal interview with the program coordinator or case manager to assess their housing situation. While they assess for many levels of housing instability—a process they repeat every six months—they rely solely on patient attestation for eligibility determination.

New Horizon Family Health Services: Greenville, SC
With its principal site in Greenville, New Horizon serves people experiencing homelessness in a thirteen-county area composing Upstate South Carolina, primarily through a 40-foot mobile medical unit. Their eligibility policies do include third-party verification, which is primarily accomplished through a network of relationships at shelters and transitional living facilities. Doubled-up patients are required to name their current or most recent host, who can be contacted separately. Their intake forms include a request for a contact person, which is most often the liaison at a nearby shelter. Unsheltered individuals who reside on the streets can usually obtain verification from local day shelters or outreach providers. These processes have not proven to be a barrier to care according to program administrators.

Neighborhood Health: Nashville, TN

The Downtown Clinic is the HCH-specific site among Neighborhood Health's various locations, and the only HCH grantee in Nashville. To be eligible for services, new patients must provide a letter of verification from a homeless services provider, known on the streets as a "homeless letter," that describes their living situation. Patients are offered a one-time exemption if they are unable to provide this letter, but with a shelter and other service providers adjacent to the campus, this is rarely difficult to obtain.

Appendix: Sample eligibility documents implemented and historically deemed compliant at HCH programs.

<Your Organization Letterhead>

Date

To <name of HCH grantee>

<Client Name>_____

currently lives in the following situation:

_____

_____

and therefore meets the US Dept of Health and Human Services federal definition of homeless under

Section 330(h) of the Public Health Service Act (42 USCS § 254b) and is eligible for federally funded

healthcare for the homeless program.

Sincerely,

Signature

<Program Director Name> or <Case Manager Name>

- **Homeless Individual** - (A) **Homeless individual**. The term "homeless individual" means **an individual who lacks housing** (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing. Definition retrieved by <program director> from website: http://bphc.hrsa.gov/policiesregulations/legislation/ on <date> (permanent supportive housing is not excluded from this definition).

<u>Affidavit Form in Lieu of Health Care for the Homeless Documentation Verification</u>

I, _____, certify that:

1. I am currently living at _____ and I am unable to provide a letter that verifies this statement.

    Signature_____   Date _____

OR

2. I am living with a relative, friend, or other, but my name is not on the lease and I am not paying rent. I am unable to provide a letter that verifies this statement.

    Signature_____   Date _____

APPLICATION

Date: _____   Time: _____

Name: _____   Date of Birth: _____

SSN: _____

Address: _____   Phone Number: _____

City/State/Zip Code: _____

Appointment Date & Location: _____

Contact Person: _____   Phone Number: _____

Please submit to HCH before individual's appointment with ████████████████████ in order for eligibility to be determined prior to appointment.

NOTE: HCH PROGRAM FUNDING WILL ONLY COVER SERVICES IF A PATIENT IS ELIGIBLE.

IF PATIENT DOES NOT QUALIFY SHE/HE WILL BE RESPONSIBLE FOR ANY CHARGES FOR SERVICES RENDERED

I certify all information is truthful and correct and I understand that if I do not qualify
I will be responsible for any charges for services rendered.

Patient Signature [SIGN HERE _____]

DO NOT WRITE BELOW THIS LINE

HCH Screening/Intake: (To be completed by HCH staff or referring agency representative)

Housing Status/ Current Residence (Check all that apply):

☐ Shelter   Name: _____   ☐ Streets/Woods

☐ Transitional   Name: _____   ☐ Doubled up   Address: _____

☐ Institution   Name: _____   ☐ Other   Please explain: _____

How long have you been in current living situation? _____   How many people live in the home? _____

Benefits/Income:

Does individual have Medicaid, Medicare, Private Insurance or VA Benefits? ☐ yes ☐ no

If yes, indicate type of coverage and ID number: _____

If no, does individual have income from work or other sources such as pension, disability, VA or other? ☐ yes ☐ no

If yes, please indicate gross income and apply for sliding fee or self-pay. _____

If no, is individual covered by a Ryan White grant or other special funding? ☐ yes ☐ no

If yes, please specify which program. _____

HCH Service Request:

Person completing referral: _____   Title: _____

Agency: _____

Phone: _____   Fax: _____

I certify that the above information is true to the best of my knowledge and the above named individual meets the HCH Program eligibility requirements.

Staff Signature [SIGN HERE _____]

The individual and/or agency initiating this referral is not responsible for any charges incurred in this referral unless specified above.

Disposition (To be used by HCH)

Client/Patient Name: _____

Services: ☐ Approved ☐ Not Approved   Initials: _____ Date: _____

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