Testimony Of Daniel Tietz, Chief Special Services Officer,
New York City Human Resources Administration

Before the New York City Council General Welfare Committee

October 14, 2015

Good morning. Thank you Chairman Levin and members of the General Welfare Committee for giving us this opportunity to testify today.

My name is Daniel Tietz and I am the Chief Special Services Officer for HRA. Joining me today is Jacqueline Dudley, Deputy Commissioner for the HIV/AIDS Services Administration (HASA).

We are here to discuss the provision of benefits and services for New York City residents with HIV and more specifically to testify in regards to Intro. No 684, also known as *HASA for All*. This Introduction would allow the City to expand existing HASA benefits eligibility to New Yorkers with HIV, but who do not have AIDS or clinically symptomatic HIV consistent with current HASA eligibility requirements. We will also address Intro. No 935 relating to the HIV/AIDS Services Administration (HASA) Advisory Board, data reporting, public comment and other non-substantive technical amendments.

HIV/AIDS Services Administration (HASA)

Arguably the world's largest and most comprehensive government program serving people with HIV and AIDS, HASA provides services and support to one of New York City's most vulnerable communities, namely those with clinically symptomatic HIV illness or AIDS. But we know that there are additional low-income New Yorkers with HIV who are not clinically symptomatic consistent with current eligibility requirements, but who would benefit from HASA services.

Much has changed since the early 1980s when a then unknown epidemic was rapidly spreading across the City, State and nation. At the time, there were no effective treatments and people did not live long after they became ill. New York City was among the first municipalities to respond and proudly provided a range of critical services to those affected by HIV and AIDS. HRA's crisis workers were providing emergency benefits and support services, as well as burial assistance, when many service organizations were reluctant to engage people with HIV.

Today's epidemic is very different from that of the 1980s or even the 1990s. What we have learned since then is when people are provided treatment, comprehensive benefits and case management they are able to experience a higher quality of life and live near-to-normal lifespans.

But much remains to be done and we are working with key stakeholders to end New York State's epidemic, which is mostly concentrated in New York City. Indeed, almost 80% of New Yorkers diagnosed with HIV in the State live in the five boroughs.

As this Committee is well aware, there is no cure for HIV and it remains a disease marked by poverty and continued stigma and discrimination. As such, HASA services are essential to ensuring that low-income New Yorkers with HIV obtain the benefits and services they need to remain healthy and live independent lives.

Although HASA presently serves only those with clinical or symptomatic HIV and AIDS, and their families, we are also focused on preventing new HIV infections. HIV transmission does not occur in isolation and although anyone of any age, race, religion, sex, gender or sexual orientation can be at risk, those at greatest risk include:

- individuals without access to culturally competent care, free condoms, clean syringes and new prevention tools, such as pre-exposure prophylaxis or non-occupational post-exposure prophylaxis;
- individuals without medical insurance and related healthcare supports;
- individuals who lack access to HIV and STI testing and screening and who experience delays or barriers in moving from a positive HIV test to linkage and engagement in treatment;
- individuals with a history of incarceration;
- individuals with status as undocumented migrants;
- men who have sex with men (MSM), particularly young black and Hispanic/Latino MSM;
- transgender individuals, especially transgender women;
- women of color;
- those who use injection drugs, but don't have access to clean syringes; and
- sero-discordant couples.

Likewise, mitigating poverty, preventing homelessness and ensuring stable and affordable housing, addressing food insecurity, unemployment and underemployment, and ensuring access to treatment for substance use disorders and mental health care are vital to both averting new HIV cases and ensuring consistent engagement in care and services for all low-income New Yorkers with HIV.

New York City's Response to The Ending the Epidemic Blueprint

In May 2015, Governor Cuomo released the Ending the Epidemic Task Force's 'Blueprint', which is a consensus document the content of which was agreed by all Task Force members, including me and the other participating City officials. The Administration fully supports the Blueprint's goals and concepts and we are working closely with our State partners to ensure the plan is implemented.

The Task Force went beyond its initial charge and included additional recommendations to ensure universal access to HIV prevention, treatment, care and support. These so-called "Getting to Zero" (GTZ) recommendations address key social, legislative and structural barriers and envision a "place where there are zero new infections, zero AIDS-related deaths and where HIV discrimination is a thing of the past." In the Getting to Zero recommendations, the first such recommendation is most directly relevant to HRA and Intro. No 684, under consideration today:

- *GTZ Recommendation 1: Single point of entry within all Local Social Services Districts (LSSDs) across new York State to essential benefits and services for low-income persons with HIV/AIDS*

This recommendation seeks to create in other Local Social Service Districts a version of HASA, which is the single point of entry in New York City for such benefits and services for persons with clinical or symptomatic HIV or AIDS. Under GTZ Recommendation 1, HASA would expand to all low-income New Yorkers with HIV, and not only those with clinical or symptomatic HIV and AIDS who are presently eligible. As with the other Blueprint recommendations we are committed to working closely with our New York State partners, as well as advocates, providers and people with HIV, to determine how best to act on this recommendation.

Intro. No 684

Tracking GTZ Recommendation 1 from the Governor's Blueprint, Intro. 684 would require HRA to expand HASA eligibility to include persons with HIV who may otherwise not qualify simply for not being sick enough.

As previously mentioned, every day the comprehensive services provided by HASA are helping New Yorkers with clinically symptomatic HIV and AIDS to live a better quality of life and to live near-to-normal lifespans. Further, by ensuring that clients are not choosing between healthcare and housing or food we are improving public health and decreasing transmission rates through continued attachment to the continuum of care. We agree with the Council that extending HASA benefits would have a similar positive outcome for low-income New Yorkers with

asymptomatic HIV, and their families, and we therefore support the goals and concepts outlined in Intro. No 684.

The costs associated with Intro. No 684 would require significant resources from both the City and State in order to expand HASA to all low-income New Yorkers with HIV. We will continue to work with our New York State partners to seek sufficient funding to expand HASA services to all New Yorkers with HIV. Likewise, we look forward to working with members of this committee and the entire City Council as the budget process begins in Albany to ensure adequate State funding to allow us to extend these lifesaving benefits to every eligible New Yorker in need of such support. Given the consideration of these matters in the upcoming State budget process, we appreciate the provision in Intro. 684 that links implementation to action by the State to provide sufficient funding.

Intro. No. 935

Intro. 935 relates to the expanded function of the HASA Advisory Board, data reporting and other non-substantive technical amendments. We are proud of our new reforms and initiatives at HRA and although it's very early, we believe our reform measures will achieve great success. As such, we want our policies and data to be clearly understood and available on HRA's website. It is a goal that is consistent with the Mayor's focus on an accessible government.

To this end, shortly after Commissioner Banks was appointed, HRA created several Workgroups that include a mix of providers, advocates and HRA leadership to discuss service challenges, barriers and policy issues, as well as potential solutions. Among these Workgroups is the HASA Workgroup, which has met several times since last summer. This Workgroup facilitates advocates and providers bringing HASA-related policy and practice concerns directly to the program and HRA's leadership so that we can collaboratively develop sensible solutions. It is an effective approach to understanding and responding to the community's needs and making policy and service improvements in HASA. The Workgroup presently meets quarterly and will be meeting again tomorrow.

HASA also maintains an Advisory Board in accordance with Local Law 49 of 1997. The Advisory Board consists of 11 individuals with five members appointed by the Council and six appointed by the Mayor, including the chairperson. At least six of the appointees are required to be eligible for HASA services. The board meets quarterly to advise the Commissioner on access and the provision of benefits and services to persons with clinical/symptomatic HIV and AIDS.

In short, HASA's senior team routinely meets with advocates, academics, elected officials, key stakeholders and clients to ensure that we are providing high-quality comprehensive services and we take their recommendations and proposals for improving service delivery, policies and procedures very seriously.

Allowing the Advisory Board additional opportunities to meet and develop robust recommendations to the Commissioner is a concept that we support. However, the bill creates some ambiguity as to whether the Board must meet quarterly and at additional times upon the request of five members, or whether the request of such members serves as an alternative to the board's chairperson convening the already-required quarterly meeting. We suggest revising the language to provide that a simple majority may override the chairperson in the event that the chair declines to call a meeting. We welcome working with you on modified language to accomplish the goal of the legislation without inadvertently impeding the ability of the Advisory Board to work collaboratively.

As previously mentioned, we agree that data reporting, revisions to the HASA Bill of Rights and revisions to policies and procedures should be transparent, available on HRA's website and subject to public comment. We suggest, however, that the proposed requirements regarding prior public review of policy changes be modified so as not to slow reform efforts. Under CAPA, we are already required to hold hearings when considering changes to policies that affect a client's rights and procedures. But as presently drafted, this bill would require more by mandating hearings that will likely serve little purpose. For example, had the proposed provision been in place last year it would have limited our ability to expeditiously implement the 30% rent cap as required by state law. We stand ready to work with the Council on modifications to accomplish our mutual goal of transparency.

Reform Efforts within HASA

At these hearings we like to take the opportunity to discuss agency reforms. As with all program areas at HRA, during the past 21 months we have been determining and implementing reforms and new initiatives within HASA to better serve our clients and ensure the best use of our staff and resources.

As mentioned above, we've instituted a HASA Workgroup, which presently meets quarterly and includes a mix of providers, advocates and HRA leadership to discuss service challenges, barriers and policy issues, as well as potential solutions. Arguably of particular relevance to HASA, we also have an LGBTQI Working Group that meets quarterly and is meeting as we speak.

But we've also instituted additional reforms and below are several of these as they relate to HASA and our clients:

- We've implemented a new cultural competency training developed by our Office of LGBTQI Affairs. Approximately 1,200 employees have been trained to date, including

269 in HASA, 825 in FIA and 105 in MICSA, with a goal of training all HRA employees in the coming year.

- We expeditiously implemented the 30% rent cap, which was first approved in the State's FY 2014-15 budget.
- We are now providing HASA clients with access to vocational services and supports to better prepare them for the workplace.
- We are consolidating securing and managing HASA emergency housing under a single master contractor to more efficiently manage this housing and the payments to multiple providers.
- We are working with key stakeholders to act on the Governor's Blueprint recommendations, including expansion of HASA to all low-income New Yorkers with HIV and not only those with clinical or symptomatic HIV and AIDS who are presently eligible.
- We are continuing to consult with the HASA advisory board in efforts to improve HASA services.

I would like to close with an overview summary of HASA services. For further detail concerning the programs and services within HASA, I refer this Committee to my June 24, 2015 testimony which can be found on the HRA website.

Overview of HASA Services

HASA services include assistance in applying for public benefits and services, such as:

- Medicaid;
- Supplemental Nutrition Assistance Program benefits (SNAP);
- Cash Assistance;
- emergency transitional housing;
- non-emergency housing;
- rental assistance;
- homecare and homemaking services;
- mental health and substance use screening and treatment referrals;
- employment and vocational services;
- transportation assistance; and
- SSI or SSD applications and appeals.

HASA clients are assigned a caseworker at one of our HASA centers, which are located in all five boroughs. Caseworkers work face-to-face with clients on applying for Cash Assistance, Medicaid and SNAP and, if eligible for HASA, can receive same-day assistance. Caseworkers assist clients by identifying their needs and creating individualized service plans to secure the necessary benefits and supports specific to addressing their needs and enhancing their well-being, taking into account the complexities of their illness. In addition to securing the public benefits noted

above, HASA caseworkers also refer and link clients to community-based organizations and providers for a host of health, mental health, substance use and housing resources.

Taken together, this investment in HASA's target benefits and services recognizes that preventing disease progression and relieving poverty saves lives, averts costs and advances health and wellness not only for individual clients, but also by helping to limit the further transmission of HIV.

HASA is mandated to provide timely delivery of benefits and services, as well as emergency housing, to all homeless HASA clients. Let me provide a brief snapshot of our current clients.

As of October 6, 2015, HASA provides services to 42,809 individuals, which includes 32,072 clients and 10,737 associated case members.

Here are a few data points regarding HASA's current clients (as of July 2015):

- The median age is 50 with 50% age 50 or older;
- 33% are female;
- More than 95% receive Medicaid and SNAP benefits;
- 24.1% receive federal SSI benefits and another 8.9% receive SSD; 4.9% receive both SSI and SSD;
- 84.7% receive Cash Assistance, including some who are also receiving SSI or SSD and for whom CA helps to cover housing costs; and
- 4.4% of clients have earned income.

Now I'd like to focus on a few key services, including housing assistance, medical assistance and financial assistance.

Housing Assistance

As of September 19, 2015:

- HASA's contracted supportive housing portfolio consists of 5,678 units of which 5,420 units are occupied. HASA spends about $134 million annually for these units.
- There are 2,672 scattered-site units available, including NY/NY III and non-NY/NY III, of which 95% (2,526) are occupied. The average annual cost per unit is $23,957.
- HASA has 2,181 permanent congregate units, including both NY/NY III and non-NY/NY III, of which 96% (2,104) are occupied. The average annual cost per unit is $22,200.
- Of HASA's 825 transitional units, 96% (790 units) are occupied. The average annual cost per unit is $25,160.

- In addition to supportive housing units, HASA is expecting to spend about $33 million this year for clients residing in emergency housing. As of October 3, 2015 of the 2,224 units available, HASA clients occupied 1,923 units, an occupancy rate of 86%.

The vast majority of HASA clients, over 19,000, live in private market apartments, with most receiving rental assistance subsidies to allow them to live independently.

Financial Assistance

Currently, there are:

- 26,786 HASA clients receiving Cash Assistance, which also includes transportation and emergency grants; and
- 30,022 HASA clients receiving SNAP benefits.

Thank you again for this opportunity to testify. I'm happy to answer any questions you may have.

TESTIMONY

TO THE NEW YORK CITY COUNCIL

GENERAL WELFARE COMMITTEE

HASA HEARING

BY Annie Soriano

EXECUTIVE DIRECTOR

FRIENDS HOUSE IN ROSEHILL

October 14, 2015

My name is Annie Soriano and I am the Executive Director of Friends House in Rosehill, a permanent supportive housing provider for HASA clients.

I would like to thank the City Council's General Welfare Committee for giving us this opportunity to testify today about HASA as well as legislation that would expand the benefits that HASA provides to include financially qualified HIV positive people.

I am here today to testify in support of Councilmember Johnson's proposed legislation. This bill goes beyond the idea of qualifying more people for HASA services. This expansion is beyond the lab criteria and medical definitions of a still epidemic virus. This epidemic is fueled by poverty, addiction, mental illness and homelessness. It's never just AIDS. It's also never just housing. The lack of stability for these most vulnerable New Yorkers presents barrier after barrier of being able to initiate treatment, have basic food, shelter and support that will allow them to live their lives as independently and as healthy as possible.

There is currently a lack of housing particularly among our city's low income, marginalized residents with HIV/AIDS. We have long known that housing is healthcare. Among the interventions that effectively address complex and intersecting health and social conditions, as well as health disparities; housing is the first priority. Housing is the key to helping people diagnosed with HIV to access healthcare, remain in treatment and prevent further transmission. Beyond housing, there is a definitive need to have access for everyone in this community to services regardless of their CD 4 count or symptoms. Diminishing barriers and enhancing access to services provides a return on investment for public health. The total cost of funding this program expansion is only a short term expenditure, it is a long term investment rather than a cost. This investment is not only with our people but also a financial long term savings. Parallel with our State's commitment and initiative to end AIDS, this expansion will invariably reduce the medical costs of life time of HIV/AIDS related care by reducing new infections. It will reduce the enormous financial costs of emergency room visits, hospital stays and will stop sacrificing the health of our clients.

We have learned lessons from the past and current state of our City being the epicenter of this disease. The disconnection from HIV care is a battle of poverty. By expanding eligibility for services; together, we will be able to provide stability for low income people diagnosed with HIV in ensuring the best possible long term wellness and an increase in self-sufficiency <u>before</u> they get too sick!

Respectfully submitted,

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Testimony of Anthony Williams
Chairman, Care for the Homeless HAC Advisory Committee
To New York City Council General Welfare Committee
Wednesday, October 14, 2015

Good Afternoon members of the New York City Council General Welfare Committee and Chairman Levin and thank you for the opportunity to speak to you today on an issue of great importance to me. My name is Anthony Williams and I have been living with HIV since 2007. I also serve as Chairman to the HIV Advisory Committee at Care for the Homeless, the oldest and largest provider of health care exclusively to homeless people in New York City, which has over 30 federally qualified health centers throughout Manhattan, Brooklyn, Queens and the Bronx.

As a homeless HASA client and member of a client advisory committee, I understand first-hand how important it is that all low-income New Yorkers living with HIV/AIDS be eligible for their services, regardless of T-cell count. It is traumatizing enough to be diagnosed with HIV. There is no need, and it's very bad public policy, to learn that you have to have a certain - and dangerously low - T-cell count just in order to receive services. This creates an enormous barrier to services including appropriate healthcare for people living with HIV/AIDS. It is an invitation to allow your health to decline when you must have a low T-cell count to qualify for their life-saving services.

This is bad public health policy and poor public policy. Our policies, just as Councilman Johnson's legislation suggests, should always be to provide these important services to anyone diagnosed with HIV. Our goal is to prevent further health declines; not require it before treatment.

I have personally known people living with HIV/AIDS, and not just a few, who were denied services not because they didn't have the disease, but essentially because the policy was for them to get sicker before they qualified for services. That's just wrong.

At the same time that HASA's services are life-saving, I also applaud Councilman Levin's legislation for greater client participation in HASA, as an avenue to improve services to HASA's clients. Client input is critical at a time when New York is turning its sight on ending the epidemic, as a necessary step to increase HIV+ patient retention and viral load suppression amongst HASA clients.

Thank you for taking the time to consider my testimony.

ACT UP NY HASA Group - Deposition at NYC Council Committee on General Welfare October 14, 2015 Council Chambers - City Hall - NYC

Thank you NYC Council Member Stephen Levin, Chair of the Committee on General Welfare, Council Member Corey Johnson, Chair of the Committee on Health and NYC Council Members here present for scheduling this hearing on HASA and for this opportunity. My name is Marcelo Maia, I facilitate the ACT UP NY/ HASA Group.

Our mission is to address HASA policies that impact clients, to update the Rental Assistance Program grant to reflect local real estate market values and other issues affecting People Living with HIV (PLHIV) **& AIDS**

The Group is spearheaded by HASA clients; representatives of major CBOs (Community Based Organizations) **working with PLHIV and housing are also members and receive notes from meetings.**

On the hearing of June 24, 2015, we distributed a list of 42 issues and 12 proposals to improve HASA. This time, we would like to focus on the proposals which are now totaling 17. Again due to time constrains I'll read the ones identified as priorities and they include the changes on HASA eligibility criteria which we endorse and to the HASA Advisory Board, which we support.

Proposals:

01- HASA rental assistance grants must be updated and reflect real estate rental market values of the neighborhood of client residence;

We argue that the HUD guidelines limits ($1,100 for a 1 bedroom) are too low and have not been updated since 2002, while rents in NYC skyrocketed. Because of that, clients with permanent housing are losing their homes and the stay for clients on SRO's is much longer. We understand that even though those are guidelines, they represent an actual limit for clients looking for housing.

As recommended to the Task Force to End the epidemic in NY State: "update the rental assistance rates provided through the program to provide rental assistance in line with fair market rental rates in localities."
http://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/recommendations/housing_support/TF60.pdf

02- HASA to screen realtors on their list and assure they are compliant with the ADA and provide updated hard copies to their case workers;

03- HASA should inform realtors that it will pay for realtor's fees;

04- HASA case works must effectively help clients find housing;

05- HASA/the City must go after landlords & real estate agents who break the law;

ACT UP NY HASA Group - Deposition at NYC Council Committee on General Welfare October 14, 2015 Council Chambers - City Hall - NYC

06- After 20 years of republican mayors, HASA needs structural and philosophical reforms;

07- HASA to survey clients, especially those in SROs with support from CBOs;

08- HASA eligibility must be granted to all PLHIV who need housing;

This proposal is being addressed by the proposed amendment to Local Law 49.

09- Case workers must be certified by HASA and evaluated by clients;

10- HASA to establish a program that will assist clients who need it, to get a GED &/or access CUNY to finish or have a college degree;

11- HASA CAB to update and display the "Client Bill of Rights" and the "List of Clients Entitlements" in every center; (Revised)

This proposal is being partially addressed by the proposed amendment to Local Law 49.

12- Schedule HASA CAB meetings, expanded membership to allow committee work, have monthly public meetings, and work with clients/volunteers. Post the HASA CAB Mission Statement and meetings schedule in every center; (Revised)

13-- Clients need to have a clear venue for complaints against providers. <u>HASA Case Worker must play the role of client advocate.</u> HASA must clarify that clients have the right to go up the leather and complain to the case worker's supervisor, levels 1 and 2, to the center director, to the regional director. This is issue needs to be addressed on the HASA Client Bill of Rights; (New)

14- Clients will be able to review and correct their records.

It was alleged that some clients are diagnosed with alcohol or chemical dependency or psychological problems in order to qualify for housing. That is issue must be addressed on the HASA Client Bill of Rights; (New)

15- No more Weekly/monthly home inspections.

Clients said that weekly and monthly visits make them feel like they are on parole. That restrictions like, they can't hang pictures, have overnight guests, paint their apartments, have a second lock on their front doors and other similar restrictions are not acceptable. (Clients will be able request a case worker visit to help solve issues); (New)

16- "The Source", a publication with rules and regulations for HRA, including HASA, must be available for client/advocates consultation at the Waverly and other Centers; (New)

17- The HASA case worker must act as a client advocate.

That includes situations when both HPD & HASA are responsible for paying rent on congregate housing or any other situation where the client needs assistance.

ACT UP NY HASA Group - Deposition at NYC Council Committee on General Welfare October 14, 2015 Council Chambers - City Hall - NYC

Clients are going through "Steps" (Eviction Process) without the HASA case worker being present. That in at least one case, the first step, conference with client, facility manager, case manager and HASA case worker did not happen and the case moved directly to step 2. Those clients go to housing court without any legal assistance (and face decisions & appeals on their own). HASA Clients must have legal representation when appearing on Housing Court.

Issues previously presented

01- The main issue is the outdated rental assistance program grant (of $1100/mo for a 1 bedroom apartment)**, which has not been updated since 2002;**

Because of that, HASA clients on permanent housing are losing their homes; clients can't find adequate housing in their neighborhoods and stays in SRO are prolonged because clients can't find adequate housing in NYC for that value.

(SRO – Single Room Occupancy are hotels that serve as transitional/temporary shelter)

02- A studio in Bed Sty is rented today by $1,300:00;

03- One member stated that "We can't find housing in NY for $1100". That is a big issue for HASA clients;

04- HASA allows clients to rent a 1 bedroom apartment , but we can't find/rent a room in Manhattan with the $1,100 limit, much less a studio or 1 bedroom apartment;

05- HASA pays more to SRO's ($1,500.00 and up) than for permanent housing;

06- HASA doesn't pay for a Security Deposit; it only gives a voucher;

07- HASA is too slow on paying the rent. HASA makes the first ½ of the payment around the 12th and the second ½ around the 25th of each month, when most rents are due on the 1st of the month;

08- HASA keeps clients/PLHIV in poverty;

09- The cash assistance limited to $ 376.00 a month (2 payments of $188,00/mo). It is not clear if clients can work or how much they can make without affecting benefits;

10- Clients have no representation in court and are accountable for rent if HASA delays or stops payments;

11- HASA should inform clients of their bill of rights, like not having their cases closed for one year if the client returns to work;

12- HASA will pay for movers, but you have to overestimate or "they may not move all your stuff" if the time allocated is not enough;

13- Clients are subjected to humiliation and discrimination by real estate agents and landlords;

14- Once again we talked about HASA list of realtors they work with being outdated, clients have no call backs or can find housing through that list;

15- HASA lists realtors sued by Housing Works;

16- Realtors in Bedsty don't accept "programs";

17- To deal with HASA & realtors is very difficult for PLHIV & disabilities;

18- HASA clients have access denied to 80/20 lotteries;

19- Clients are forced to disclose their HIV status to real estate agents and landlords by sharing they are on HASA;

20- One member stated that he had his application for a Studio for $1,100 in Far Rockway denied, because "they stopped accepting program people";

21- A member mentioned and agency Abba Realty in Brooklyn and an agent, Mike Stern, who works there and has found housing for HASA clients;

22- Landlords in order to get rid of tenants can report HASA clients to the city Bureau of Investigations and the client must submit to the investigation or have their case closed by HASA. That not only implies loosing your home but also MEDICAID, treatment and care;

23- PLHIV feel stuck in SROs. While the maximum time for a HASA client to live in a SRO is 6 months, clients can easily spend more than 1 year, living is shady hotels before finding housing, which will probably be far in the boroughs outside Manhattan;

24- SRO workers don't effectively help clients find permanent housing. It is valid to note the conflict of interest of workers from SROs, who are paid by HASA to house clients and at the same time are also responsible to help clients find permanent housing;

25- If a client lives in a SRO, HASA will pay over to $1,100.00 for realtor's fees, but realtors don't know that;

26- PLHIV in SROs in Manhattan don't even look for housing in the borough;

27- SROs are notorious for rampant drug trafficking, theft and violence;

28- Sexual abuse, including rape in SRO's, are not followed through;

29- Poor health and safety of HASA clients in SROs;

30- Some SRO's designated for clients with drug abuse history, have a curfew but clients without that history are also housed in such SROs for lack of housing;

31- Some HASA case workers are not qualified to properly assist clients;

32- Case workers follow different rules in different for HASA offices;

34- HASA case-workers don't facilitate finding housing or help clients find an apartment;

35- A member mentioned being pressure by the HASA case worker to make him move from a SRO;

36- HASA treats clients on a case by case basis; sometimes paying over the $1.100 ceiling with at least one case of $1,700/ month rent being covered. They have over 30,000 clients and treat them distinctively;

37- HASA case workers are not certified, sometimes have no computer skills or knowledge of HASA procedures;

38- There is no easy venue to address HASA complains. HASA has a Client Advisory Board (CAB), but meetings are sporadic and not open to the public;

39- HASA policies limit membership to PWAs or PLHIV who also have a history of at least two opportunistic infections. PLHIV need stable housing to be able to start and adhere to treatment, achieve viral suppression, become undetectable and become unable to transmit the virus;

30- Every year more and more people become HIV positive and may qualify for HASA, but the housing budget or the number of HASA clients doesn't reflect that;

41- One member stated that he feels like felon, because of monthly visits by HASA case workers and that he has to send them a letter every time he travels;

42- HASA mandates clients who don't qualify, to apply for SSI & SSD every 6 months, when they know the application will be denied, or demand PRUCOL letters, when the client legal status has not changed.

We understand that permanent housing is fundamental if PLHIV are to be tested, connected and remain in care, start treatment, suppress viral replication, achieve maintain an undetectable viral load and stop HIV transmissions. It is also known that NY Task Force to End the AIDS Epidemic (ETE), has recommended that HASA like services be extended throughout NY State. We must not replicate a model which has known problems before we correct them. We will work on transforming the concept of permanent housing into that of a home for PLHIV in NY.

ACT UP NY
www.actupny.org

Thank you for having this meeting on proposed changes to the Hasa rules. I am James Edstrom and have been in the abusive Hasa system for over 14 years. I have been profiled on 60 minutes, Good Day NY, Access Hollywood and every other television show. I have been abused by the HRA and Hasa.

IN HASA WE ARE UNDER HOUSE ARREST THE MINUTE WE ARE DIAGNOISED WITH AIDS

I am currently in supreme court with Hasa's provider St Nicks Alliance for abuses including breaking rent stabilization laws, harassment, living with rats and mice, abuses by landlord and caseworkers and breaking the Americans With Disabilities Act which states "EQUAL OR BETTER HOUSING". Most of the HRA's providers break these laws and the HRA refuses to do anything about it, even when proven. These housing contracts the city signs with these providers are illegal .

There are already rules in place at the HRA for people living with AIDS. They mean nothing to the HRA and Hasa staff. There are no safeguards in place to protect us, there is no system for us to complain and call a provider in to the HRA, But the Provider can call us in for any little thing for the STEP 1, 2 and 3 process then eviction. When you are called into one of these step meetings, even when you prove you are right, the HRA sides with the provider. This is wrong.

After I begged for almost 3 years for the HRA to do something about the abuses, they ignored. When I finally had it, I was forced to go public in the NY Daily News and say I had AIDS and tell about the abuses. At the same time I filed a lawsuit against the provider in Supreme Court. This did not even make the HRA or the provider do the right thing and fix the abuses. In fact it outraged the HRA and St Nicks Alliance and the abuses became worse.

My Lawyer informed the HRA and St Nicks Alliance that since we now had a lawsuit, all action against me was to stop as required by law. It did not.

I not only complained about the abuse from the landlord, I complained about the drugs in the building and St Nicks Alliance not only refused to address the drug problems, they refused to give the video to the police of drug deals I wittnessed. If anyone read the story of the big Heroin bust in Brooklyn a few weeks ago, the woman accused of money laundering for the drug opperation was the St Nicks Alliance property manager Haydee Cordero. Her son ran the operation. St Nicks operates or owns around 80 buildings in Brooklyn.

The HRA knowing there was a ongoing lawsuit still allowed St Nicks Alliance to file a Step 1 against me and when I attended with my lawyer and proved all the allegations were false the HRA still ruled against me. My lawyer once again informed the HRA that since there was a ongoing lawsuit against St Nicks Alliance, they could not allow any more of these Step meetings. Shortly after, the HRA called me into a Step two meeting for more false charges.

Once again my lawyer and I went to this meeting. At the meeting we proved we were living with mice and rats, we proved we were being abused and we proved St Nicks Alliance forged my lease agreement. They had testimony from their own HRA employee who was at the lease signing and she said the leases were forged, that I never agreed to certain things and still the HRA ruled against me. Joining Hasa means you are under house arrest and have no rights. There is no system in place to protect us from these landlords AKA Providers.

My apartment cost the city over 22 hundred a month plus my rent portion. This money is supposed to be for services, there are no services from these landlords. They are basically jail guards who threaten you with eviction every time you complain about housing or services.

SOME HASA FACTS

When you go to Hasa they do not tell you you will be labeled as a drug addict and a alcoholic in order to get housing. The Hasa program is a duplicate of the cities drug program. Is this fair? I caught them doing this and I contacted former Commish Robert Doer and had several phone calls with deputy Commish Frank Lipton. They said this is the way it is so they can get extra funding. I asked them in dozens of e mails to change this, they refused. Is this fair?

You can be evicted for just about anything from these landlords-providers. St Nicks Alliance required us to have a Verizon phone line, even know I had a cell phone, I was not allowed to get a dog or cat, even know everyone in the building had. You can not have a chain lock on your door, even know the law requires the landlord to allow this. You can not paint your apartment, you can not hang pictures on the wall, you can not carpet and so many more things. And you are forced to have weekly visits from these landlord caseworkers who give no services. The HRA rules state, any service can be refused. But if you refuse to meet with these landlord caseworkers, you are subject for eviction. This is a violation of not only our civil rights, its against the Americans With Disabilities Act as well as Rent Laws and McKenneys law.

The only one who benefits from these housing programs are landlords. I had a face to face with Hasa commish Daniel Tietz and he danced around all my questions. The HRA is also close to

breaking Rico laws as they have paid off all the organizations that used to fight for our rights. Example. They hired Daniel Tietz because he used to run Housing Works. What better way to conquer than to hire the General from the other side. Now they give grants to Gay Mens Health Crisis which means they will not go against the HRA and Hasa because they will not bite the hand that feeds them. One recent friend who went there for eviction help was told they could not go against the HRA, they give them funding. I got my lawyer to stop the eviction, and the eviction was for a dog, which everyone in the building has, but if you have AIDS, you can not. This is not equal or better housing as required by law.

I am now out of the provider system. I moved to the private market. The city now saves over 30 thousand a year by not paying for these services that do not exist. The city also saves on contract fees and maintenance fees for the apartment as St Nicks Alliance forbids us from using the building super so they can bilk the city out of every dime. Hasa is a broken system and the HRA knows this.

I would apriciate as many questions as you can ask, I by now am a expert on this corrupt system.

Thanks you, James Edstrom

FOR THE RECO[illegible]

HARLEM UNITED

TESTIMONY to the Committee on General Welfare
New York City Council
Int. 684: Expanding the Population Served by HASA

Danielle Strauss, MPH
Associate Vice President for Housing

October 14, 2015

Thank you for the opportunity to testify before you today. My name is Danielle Strauss, and I am an Associate Vice President for Housing at Harlem United.

Harlem United has enjoyed a strong and productive relationship with HIV/AIDS Services Administration for many years. We are an organization vastly experienced in providing critical health, housing and human service to people with multiple needs. With more than 600 units of supportive housing – half of which are funded with HASA contracts – 2,500 primary care visits to our Federally-Qualified Healthcare Center, adult day health services, mental health, harm reduction, community-based outreach and preventive screenings, Harlem United is able to "level the playing field" for more than 14,000 New Yorkers each year. Many of these individuals are among the most economically-disenfranchised individuals in New York City – homeless or unstably housed, living with HIV or AIDS, Hepatitis C, Diabetes, extreme poverty, substance use, and mental illness. We serve the most vulnerable citizens of New York and are, for many, the service provider of last resort.

We appreciate the opportunity to submit testimony before the General Welfare Committee today and urge you to support Int. No. 684, a proposal to provide access to HASA housing and other subsistence services to all income-eligible New York City residents who are HIV-positive, regardless of disease stage. We know that safe, stable housing, food security and transportation support are essential components of HIV healthcare and necessary to support early access to ARV treatment as soon as possible following HIV diagnosis.

Harlem United knows this first hand. As a member of the End AIDS NY 2020 Coalition – and member of the Governor's Ending the Epidemic Task Force – we are working to find resources to support this proposed legislative change on the local and state levels.

We believe that, right here in New York City, HASA eligibility should be expanded to serve HIV+ individuals – in addition to those living with AIDS –for the following reasons:

1. Research suggests that people with HIV/AIDS who are homeless or unstably housed have worse overall physical and mental health. Their CD4 counts are lower and their viral loads are higher. They are less likely to receive and adhere to antiretroviral therapy, and they are more likely to die prematurely.

2. We feel strongly that supportive housing services for all individuals with HIV dramatically improves the quality of these homeless individuals' lives. Housing improves individual health outcomes and reduces cost to society by reducing the number of unnecessary visits to the ER and hospital as well as incarceration.

3. To demonstrate this, Harlem United, with MRT funding from the AIDS Institute, initiated a pilot project to provide a rental subsidy plus supportive housing services to 50 HIV positive but non-HASA eligible homeless individuals, last year. This was implemented as part of an iHealth Health Home initiative.

    a. Since inception, the program housed 26 clients in scatter site housing, 24 of whom remain housed to date.
    b. These clients contribute the $215 towards their rent from PA or pay 30% of their income from SSI or employment and Harlem United pays the remainder of the rent with grant funds.
    c. Without this program, these 24 individuals would not be able to afford housing in NYC and would be living in the shelter system today, or doubling up with family or friends at risk of being kicked out at any time.
    d. Since being stably housed:
        i. 79% of the clients enrolled in this pilot program have been to their PCP within the past 6 months and 83% have maintained an undetectable viral load.
        ii. 79% reduced their risk of housing instability, based on the results of a risk assessment evaluation tool administered at baseline and 6 month follow up.
        iii. 63% paid their portion of the rent in September.
        iv. Four are working full time, two are enrolled in school and 16 are engaged in mental health and/or substance abuse treatment.

We urge you to expand HASA eligibility to serve so many more HIV+ individuals in need of housing. Thank you for your time and attention today.

Feel free to follow up with me directly with any questions or comments at dstrauss@harlemunited.org.

NEW YORK CITY COUNCIL COMMITTEE ON GENERAL WELFARE
CHAIR – STEPHEN LEVIN

October 14, 2015 at 10 A.M.

Good morning, my name is Michael Czaczkes and I am the Director of Policy and Public Affairs at the Gay Men's Health Crisis (GMHC). Today, I will be testifying on behalf of GMHC in support of Intro Number 684, sponsored by Council Member Johnson and Intro Number 935, sponsored by Council Member Levin.

GMHC is the world's first AIDS service organization. Based in New York City, we are a not-for-profit, volunteer-supported and community-based organization that has been a leader since 1982 in the national fight to end HIV and AIDS. We offer a wide range of comprehensive client services, including hot meals, benefits enrollment, healthcare advocacy, case management, legal assistance, HIV counseling and testing, individual and group counseling services, prevention education, and mental health services. In 2014, we served 9,336 clients across New York City. Our clients reflect the diversity of the HIV epidemic:

55% identify as Latino or Black;
47% identify as lesbian, gay or bisexual; and
54% reside outside Manhattan[1]

In addition to direct services, GMHC provides public policy advocacy, which is why I am here today. A look back at our 2008 "City Policy Agenda" shows support for the expansion of benefits from the HIV/AIDS Service Administration (HASA). Since then, we have continually fought to expand benefits to allow more New Yorkers to qualify for housing, nutrition, and transportation benefits because we know that housing is key to ending HIV and AIDS in New York. Today, this efforts is known as HASA for All.

The problem is that current HASA regulations require those who receive benefits to have an AIDS diagnosis or symptomatic HIV infection, meaning a T-cell count of 200 or less or two opportunistic infections, such as pneumocystis carinii pneumonia (PCP) or toxoplasmosis. HIV-positive New Yorkers who do not meet the medical requirements cannot receive benefits. While these regulations have remained unchanged, we have seen treatments reducing the number of people who progress from HIV-positive to AIDS.

In turn, we have heard stories for years of New Yorkers stopping their treatments in order to become sick enough to qualify for HASA. Sadly, these stories are not surprising given a 2014 report from the City Comptroller on the state of housing in New York City. From 2000 to 2012, median apartment rents in the city rose by 75 percent, compared to 44 percent nationally. During

[1] Client Demographics: January 1 – December 31, 2014. Gay Men's Health Crisis. Retrieved October 13, 2015 from www.gmhc.org/about-us/client-demographics

this time, housing affordability, defined by rent-to-income ratios, had the harshest consequences for poor and working class New Yorkers earning less than $40,000 a year.[2] Those affected by HIV and AIDS in New York City must be a part of the current dialogue on city's affordable housing shortage.

GMHC, along with members of Governor Cuomo's *Ending the Epidemic* Task Force, know that in order to achieve and maintain viral suppression, which is the clearest indicator that appropriate medical care is being provided, a person with HIV needs a host of non-medical resources. Persons with HIV who lack jobs, housing, financial resources, and adequate insurance are less likely to achieve improved health outcomes.[3] Despite this, there are an estimated 10,000 to 15,000 people with HIV who remain medically ineligible for critical benefits[4] such as non-shelter housing assistance, case management, and transportation allowance.

In addition to HASA for All, Intro 935, in part, creates a new advisory board with membership including persons with clinical/symptomatic HIV illness or with AIDS. Participation is essential in public policy decision-making and delivery. This board will give people living with HIV and AIDS a more direct voice regarding the provision of benefits and services and access to benefits and services. This newly created board would provide the agency with a range of views and concerns. The job of the agency will then be to balance these views and concerns and reflect back decisions so that the public understands how its diverse concerns were considered.

Thank you to Chairman Levin and the Committee on General Welfare for hosting today's hearing.

Contact:

Michael Czaczkes
michaelc@gmhc.org or 212-367-1185

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[2] The Growing Gap: New York City's Housing Affordability Challenge. Office of the New York City Comptroller Scott Stringer. Retrieved October 13, 2015 from http://comptroller.nyc.gov/wp-content/uploads/documents/Growing_Gap.pdf

[3] 2015 Blueprint to End AIDS. New York State Department of Health. Retrieved October 13, 2015 from www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf

[4] Ending the Epidemic Task Force Committee Recommendation. New York State Department of Health. Retrieved October 13, 2015 from www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/crs/cr34.pdf

Testimony of Chris Mann, Health Advocate,
The Partnership for the Homeless

Before the New York City Council General Welfare Committee

October, 2015

On behalf of the Partnership for the Homeless, thank you for the opportunity to testify in favor of the proposed legislation. My name is Chris Mann and I am a health advocate at the Partnership. In that role, I have worked extensively with low-income, HIV positive individuals providing health education to promote increased health outcomes. Despite the value of these services, finding a permanent place to live is often the first priority of our clients and at the Partnership for the Homeless we believe in a housing first model. When it comes to connecting a client with housing, their HASA eligibility is one of the main factors that will determine the difficulty they experience finding a home. It is clear that HIV and homelessness are deeply connected issues. Studies indicate that as many as half of individuals with HIV/ AIDS are at risk of homelessness.[1] Furthermore, homeless people experience HIV infection at ten times the rate of the general population.[2]

Housing status is one of the strongest predictors of health outcomes for PLWHA.[3] In particular there is a need for permanent housing and not just shelter. If a client is HIV positive and not eligible for HASA, the likelihood that they will find permanent housing within a reasonable timeframe is greatly diminished. For many, this means longer stays in the city's shelters where their health often deteriorates due to poor sanitation and other adverse conditions.

One of the main issues created by life in the shelter or on the street is its effect on treatment adherence. One client reported that finding a confidential space to take his medications was always an issue in the shelter. This made it nearly impossible for him to develop a consistent

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[1] NATIONAL ALLIANCE TO END HOMELESSNESS. 2006. *Fact Sheet :Homelessness and HIV/AIDS.* August 10. Accessed October 08, 2015. http://www.endhomelessness.org/library/entry/fact-sheet-homelessness-and-hiv-aids.

[2] National AIDS Housing Coalition . 2009. *HIV/AIDS Housing Breaking the Link Between Homelessness and HIV.* June 3. Accessed October 08, 2015. http://www.nationalaidshousing.org/PDF/breakinglink.pdf.

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routine, which would not be an issue if he had permanent housing. Lack of adherence leads to higher viral loads and a higher risk of transmission.

Housing status is a discussion that I have with all of my clients. In one such discussion with a client who was HIV positive but not HASA eligible, I asked him where he was staying. He stated "I'm a gay man in the age of GRINDR; I can always find a place to sleep," implying he was having sex in exchange for a roof over his head. His response highlights one of the many negative consequences of denying HASA to individuals who are HIV positive but are not yet considered "sick enough" to be eligible. This behavior is risky – particularly for someone who is living with a compromised immune system. By expanding HASA benefits to all low income people living with HIV, people like my client will have a much better chance at securing permanent housing. By having a permanent place to live, he would no longer have to choose between sleeping with a stranger and having nowhere to sleep at all.

Thank you again for this opportunity to testify and I welcome any questions you might have.

THE PARTNERSHIP FOR THE HOMELESS

Testimony of Chris Mann, Health Advocate,
The Partnership for the Homeless

Before the New York City Council General Welfare Committee

October, 2015

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Thank you again for this opportunity to testify and I welcome any questions you might have.

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HASA for All

General Welfare Committee Hearing

Good Afternoon,

Thank you for giving me the opportunity to talk to you today about an issue of great concern to me both personally and professionally.

My name is Jezwah Harris and I represent New York Law School's Legislative Advocacy Clinic and myself. I have skin in this game, if you will (I have significant experience in this area on multiple levels) …I am a student attorney, a nurse and a HIV/AIDS Services Administration (HASA) Client.

I thank Council Member Corey Johnson for his leadership on this issue[1], and all the other Council Members who are working to address an underserved demographic in New York City's HIV+ population and to confront a lack of transparency[2] on

[1] New York City Council *Intro Number 684*, "A Local Law to amend the administrative code of the city of New York, in relation to the provision of services to people living with HIV and AIDS." Sponsored by Council Members Johnson, Levin, Palma, Dromm, Menchaca, Mendez, Torres and Van Bramer.

[2] New York City Council Intro *Intro Number 935*, "A Local Law to amend the administrative code of the city of New York, in relation to the division of AIDS services."

the part of the HASA Division of New York City's Human Resource Administration (HRA).

Many of you may be familiar with Governor Cuomo's Blue Print for Ending AIDS.[3] New York City has accomplished only a 5% decrease[4] in the rate of new HIV infections; this is inadequate progress for a city that has an entire agency devoted to serving symptomatic HIV and AIDS clients. We are slipping from previous years[5] and we can and must do better.

One barrier to real progress is that the City of New York is only serving the symptomatic population.[6] If we are to reach the goals set by Governor Cuomo earlier this year we must reach a broader population, reach them earlier, and provide all necessary supports. We must get all HIV+ individuals into available services immediately after testing positive and we must assist in the adoption of HIV Pre-Exposure Prophylactic Therapy (PrEP) among high risk populations.[7]

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[3] *2015 Blueprint for achieving the goal set forth by Governor Cuomo to end the epidemic in New York State by the end of 2020. "Get Tested. Treat Early. Stay Safe. End AIDS."* New York State Department of Health, health.ny.gov/ete

[4] This was computer using the *2013 Annual Surveillance Report,* New York City Department of Health and Mental Hygiene and the projected 2014 totals based on the *2014 HIV Surveillance Mid-Year Report.* New York City Department of Health and Mental Hygiene. The projected 2014 new infections were calculated by doubling the six-month new infection total.

[5] Based on comparing the *2012 Annual Surveillance Report,* New York City Department of Health and Mental Hygiene and the *2013 Annual Surveillance Report,* New York City Department of Health and Mental Hygiene. We decreased ten percent 2012-2013, but only five percent 2013-2014.

[6] 38 NYCRR § 5-01(a), *Rights of Person with Clinical/Symptomatic HIV Illness or with AIDS.*

[7] The Associated Press, UN: HIV Patients Should Start Treatment Immediately (Health ed. http://nyti.ms/1KKqHjj New York Times 2015).

of HIV Pre-Exposure Prophylactic Therapy (PrEP) among high risk populations.[7] We have to keep patients Anti-Retroviral Treatment (ART) compliant to achieve a substantial reduction in new HIV infections.

The World Health Organization and the Centers for Disease Control are now in agreement and recommend that anyone who tests HIV+ should be treated immediately because early treatment keeps those with the virus healthier and reduces the risk of transmitting the virus.[8] Early and preventative treatment can reduce the transmission of HIV by up to 99% with up to 94% of those on treatment reaching undetectable sanguineous viral loads.[9]

Frankly there is a lot of work for New York City to do, and it can start with the Council. Two major hurdles with ART initiation and compliance are a single point of access and stable housing[10], both of which HASA should provide for all current HIV+ person and those who are diagnosed in the future. The single point of entry is crucial because it gives those in need of both medical and social services a fixed point to be referred to by the diagnosing healthcare provider or collaborating allied health professionals. Client referral numbers from

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[7] The Associated Press, UN: HIV Patients Should Start Treatment Immediately (Health ed. http://nyti.ms/1KKqHjj New York Times 2015).

[8] *Supra. Please see footnote 7.*

[9] NAM (National AIDS Map), No-one with an undetectable viral load, gay or heterosexual, transmits HIV in first two years of PARTNER study (2014), http://www.aidsmap.com/No-one-with-an-undetectable-viral-load-gay-or-heterosexual-transmits-HIV-in-first-two-years-of-PARTNER-study/page/2832748/.

[10] *Supra. Please see footnote 3 at page 24, 29.*

June of 2015 show that approximately 50% of all HASA clients are self-referred.[11] New York should be sending the newly diagnosed to HASA not leaving the patient to conduct a search for available help. The single-point approach provides us an opportunity. HASA should also be a place where those at high risk can seek assistance with other services such as Medicaid or other government programs. This would create the need for more caseworkers, but the potential savings to the in treatment dollars could be as high as $300,000,000 per year.[12][13]

On the housing side, the Council can start by addressing transparency issues at HASA that make it difficult to navigate for clients. HASA currently has programs in place for both ongoing and emergency housing. These HASA programs take two primary forms as either units leased by HASA or privately rented market-rate apartments.[14] HASA spends an average of $1958 per month on 5701 leased units[15], whereas the 23,000 clients with privately rented units receive between $440 and

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[11] *HASA Facts*, City of New York Human Resources Administration, June 2015

[12] *Supra. Please see footnote 3 at page 8. This is based on a cost of $357,498 per person at 16.7 infections per 100,000 persons.*

[13] New York City has a population surpassing eight million which would predict 1336 new HIV infections per year. This is a low estimate as New York City hit 1350 new infections in the first half of 2014.

[14] *Transcript of the Minutes of the Committee on General Welfare*, City Council, City of New York page 20 lines 9-21 (June 24, 2015) (Testimony of Daniel Tietz and Jacqueline Dudley).

[15] *Transcript of the Minutes of the Committee on General Welfare*, City Council, City of New York page 21 lines 7-10 (June 24, 2015) (Testimony of Daniel Tietz and Jacqueline Dudley).

$1100 in rental assistance per month.[16] However, HASA does not make the criteria to get the $1100 available to clients[17] and the approval process is arbitrary and shrouded in mystery[18], meaning people can be receiving vastly different supports for no obvious or justified reason.[19]

The lack of stable housing access not only forces HIV+ people out of their homes, but given the current demographic makeup of the newly infected, it also has a population transfer effect.[20] This effect appears to be racially discriminatory and forces people to the outer boroughs where there are far fewer supports available. Even though all of these clients should qualify for the 30% income rent cap that was enacted last year it is not currently being applied to all HASA qualified participants as the state law intends.[21]

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[16] Signed Letter from a HASA Center Supervisor indicating that they will approve up to $1100 in rental assistance. The $440 is the statutory minimum under 18 NYCRR § 352.3.

[17] Email from HRA attorney indicating that they would not release this information when it was requested by a client in relation to on going rental assistance Article 78 proceedings.

[18] *Transcript of the Minutes of the Committee on General Welfare*, City Council, City of New York page 113 lines 13-19 (June 24, 2015) (Testimony Reginald Brown).

[19] Decision documents from HASA that indicate denial of rental assistance in the amount of $1100. *Transcript of the Minutes of the Committee on General Welfare*, City Council, City of New York page 99 lines 6-12 (June 24, 2015) (Testimony of Daniel Tietz and Jacqueline Dudley).

[20] *Supra. Please see footnotes 4, 5, and 11.* Comparison of newly diagnosed HIV+ patients, most of whom lived in Manhattan at the time of diagnoses, but when compared to HASA service statistics show most clients now not domiciled in Manhattan.

[21] *Transcript of the Minutes of the Committee on General Welfare*, City Council, City of New York page 7 lines 8-10 (June 24, 2015) (Testimony of Daniel Tietz and Jacqueline Dudley).

I want the Council to understand the positive impact that "HASA for All" and greater transparency will have on the currently marginalized and underserved HIV+ population of New York.

Today I ask for your support for both the "HASA for ALL" Bill and the "Division of AIDS Services Bill"

Thank you for your time today.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☑ in favor ☐ in opposition

Date: 10/15/15

(PLEASE PRINT)

Name: Danielle Strauss

Address: 306 Lenox Ave., NY, NY 10027

I represent: Harlem United

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 935 Res. No. ______

☑ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Rev. Antionettea Etienne

Address: 2271 2nd Av.

I represent: Iris House, Inc.

Address: 2348 7th Ave. NYC

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: 10-14-15

(PLEASE PRINT)

Name: Jacqueline Dudley

Address:

I represent: HRA - HASA

Address: 12 W. 14th Street 5th Floor

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 10-14-15

(PLEASE PRINT)

Name: Daniel Tietz

Address:

I represent: HRA - HASA

Address: 4 World Trade Center 42nd Floor

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 684 Res. No. ________
☒ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Dr. Alvin Ponder

Address: 140 Bellamy Loop/Unit 2C, Bronx, NY

I represent: HIV/AIDS Committee of the National Action Network

Address: 106 West 145th St, Harlem, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 684 Res. No. ________
☒ in favor ☐ in opposition

Date: 10/14/15

(PLEASE PRINT)

Name: Chris Mann

Address: 248 Mckibbin St. #4N Brooklyn NY 11206

I represent: The Partnership for the Homeless

Address: 395 7th Ave 14th Floor NY, NY 10001

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 935, 684 Res. No. ______
☒ in favor ☐ in opposition

Date: 10/14/15

(PLEASE PRINT)

Name: Jezwali Harris
Address: 456 W 167th St. Apt. 3H NY 10032
I represent: New York Law School, Myself
Address: 185 W Broadway NY 10013

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☒ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: MARCELO MAIA
Address: 621 E 11 ST #3A, NY, NY 10009
I represent: ACT UP
Address: ______

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 10/14/15

(PLEASE PRINT)

Name: Tassy Canlice
Address: 121 West 20th Street
I represent: Village Care
Address: 121 West 20th Street

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 10/14/15

(PLEASE PRINT)

Name: JAMES EDSTROM
Address: 1-55 BORDEN AVE LIC
I represent: ______
Address: LONG ISLAND CITY 11101

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 684 Res. No. ______
☑ in favor ☐ in opposition

Date: 10-14-15

(PLEASE PRINT)

Name: Michael Czaczkes
Address: 446 W 33rd St
I represent: GMHC
Address: 446 W. 33rd St

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☑ in favor ☐ in opposition

Date: 10/14/15

(PLEASE PRINT)

Name: Reginald T. Brown
Address: ______
I represent: VOCAL-NY
Address: ______

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: 10/14/2015

(PLEASE PRINT)

Name: IVAN PEREZ

Address:

I represent: Vocal EMHC

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 684 Res. No. ______
☑ in favor ☐ in opposition

Date: 10/14/15

(PLEASE PRINT)

Name: JAMES LISTER

Address: 148 BANK ST

I represent: VOCAL-NY

Address: ~~146 BAN~~ 80A 4TH AV BK

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 684 Res. No. ______
☒ in favor ☐ in opposition

Date: 10/14/15

(PLEASE PRINT)

Name: ANNIE Soriano

Address: 130 E. 25th St., NY 10010

I represent: Friends House

Address: 130 E. 25th St., NY 10010

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☒ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: GINNY SHUBERT
Address: 57 WILLOUGHBY ST, BK
I represent: HOUSING WORKS
Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☒ in favor ☐ in opposition

Date: 10/14/15

(PLEASE PRINT)

Name: Clarence Henderson
Address: 505 E. 183 St. #1B
I represent: BOOM Health / myself
Address: 540 E. Fordham Rd.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. transgender's Res. No. whith HIV
☑ in favor ☐ in opposition

Date: Oct /14/2015

(PLEASE PRINT)

Name: Josephine Perez
Address: 147 West 24th street 3rd FLOOR
I represent: trans justice
Address: MY Address is 454 Lexington AV and throop BROOKLYN NY NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 938 Res. No. ______

☒ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: JENNIFER FLYNN

Address: 105 LINCOLN RD. #5C BK, NY

I represent: VOCAL-NY

Address: 80A 4th Ave. Bk, NY 11217

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Anthony Williams

Address: Care for Homeless

I represent: ______

Address: ______

Please complete this card and return to the Sergeant-at-Arms