Understanding Housing & Health Home Integration

Hudson Valley Region

Presented By
Kristin Miller, NY Program Director
Pascale Leone, Sr. Program Manager

What We’ll Cover

Housing Universe in NY
Supportive Housing
Health Homes
Integrating Health & Housing
Housing Options in New York

Shelter/Housing Universe in New York
Housing Categories In New York

Residential Programs

Emergency Shelter
- Shelter
- DV Shelter
- HASA
- Faith beds
- Hotels/Motels
- Boarding Homes

Transitional Programs
- Long-term Treatment
- CR SRO
- ½ & ¼ Housing
- Safe Haven
- Apartment Treatment Program
- Respite

Market Housing
- Typical market rate rental housing

Affordable Housing
- Public Housing
- Section 8
- Home Ownership
- SCRIE
- DRIE
- 80/20
- HOYO

Permanent Supportive Housing
- Supportive SRO
- NY/NY
- S+C
- HUD VASH
- MRT
- DV
- HASA
- Supported
- SSVF
- Upstate PSH
- HOPWA
- Sect. 811

Other
- Warming/Drop-in Centers
- Jail*
- Nursing Home*

Housing Categories In New York

Emergency Shelter

Faith-based Shelter
- Over 200 faith-based beds in New York City located in places of worship
- Drop-in centers

Drop – In Centers*
- Provide hot meals, showers, laundry, clothing, medical care, recreational space.
- Typically no sleep-in beds. Connects people with case managers. For chronically street homeless, or other hard-to-reach homeless
- Referrals from street outreach; drop-in center

Warming Centers
- Short-term emergency shelter that operates when temperatures and/or precipitation has become dangerously inclement.
- For single adults and families in need
- NYS – Not-for-profit agencies; NYC – 311

Hotels/ Motel rooms
- Temporary housing for homeless individuals/families. Usually placed when shelters are full. Difficult to provide services in hotels/motels.
- Typical stay is a month – goal is to get into housing
- Homeless families/ individuals
- DSS does pay for the vouchers
### Housing Categories In New York

#### Emergency Shelter

**DHS Shelter**
- Centralized intake for men, women and families
- Intake process to be deemed homeless and eligible for shelter. Client is assigned to one shelter
- NYC only

**HASA**
- Temporary emergency housing and non-emergency housing
- Homeless individuals with HIV/AIDS or homeless families with individuals living with HIV/AIDS
- NYC only HASA Application

**DV Shelter**
- Temporary emergency shelter (90-135 days) to domestic violence victims
- NYC's Domestic Violence Hotline at 1-800-621-HOPE 24/7

**Housing Preservation & Development Emergency Shelter**
- HPD's Emergency Housing Services Bureau assists displaced tenants with temporary housing at one of four family centers or at Red Cross-contracted hotels and facilities
- NYC’s HPD (212) 863-8561

---

#### Transitional Programs

**Long-term Treatment** *(Scattered-site or Congregate)*
- Shared apartments in community for individuals with substance abuse or substance abuse and co-occurring mental illness. Typically 18+, Level II
- OMH, OASAS

**CR SRO** *(congregate)*
- Community Residences/Single Room Occupancy: Usually 2-5 years before they transition to more independent living. Level II
- Chronically homeless, SPMI or MICA single adults. Preference for those discharged from long-term psychiatric hospitalization.
- OMH

**Nursing Homes/Adult Care Facility**
- Assessment completed by RN; forms valid for 30 days for hospitalized individuals & 90 days for those who are in any other setting, including their home (required by NYS DOH)
- For adult care, must apply to the individual, privately-owned facility

**¾ Houses aka Sober Homes** *(congregate)*
- The congregate sites are not licensed by a NYS authority
- There are at least 500 such “Sober Home” beds on Long Island and another 500 in NYC
### Transitional Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
</table>
| Apartment Treatment (Scattered-site) | • Shared apartments in community for individuals with mental illness or substance abuse. Provides an apartment in the community with staff visits as necessary to provide rehabilitative services designed to improve functioning and develop greater independence. Typically 18+, Level II  
• Eligible individuals must have Medicaid and/or SSI, SSD or be on public assistance.  
• NYS – SPOA; NYC – HRA 2010e; NYS - OMH; Operated by non-profit agencies |
| Safe Haven               | • Housing and rehab services for hard to reach homeless population with SMI who aren't engaged in conventional housing/outpatient treatment  
• NYC – Drop-in centers are usually the portals of entry for Safe Havens |
| DV Housing               | • Provides temporary safe housing and support services (i.e. emergency housing, hotline, support groups, case management and court services) for victims of domestic violence.  
• Can be accessed directly or Dept. of Social Services |

### Affordable Housing

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
</table>
| Public Housing           | • Affordable housing for low- and moderate-income residents  
• 18+, income restricted/ criminal background restrictions  
• NYS – Local PHAs; NYC – NYCHA |
| Section 8                | • Tenant-based vouchers to extremely low-income (30% AMI), very low-income (50% AMI) and low-income (80 % AMI) families living in the State of New York (project-based or individual "portable" vouchers)  
• 18+, Income-based, restrictions (background)  
• NYS – Local PHAs; NYC – NYCHA |
| 80/20                    | • Multi-family rental developments where at least 20% of units are set aside for very low-income residents (50% or less local AMI)  
• Similar to 80/20 but targeted specifically to homeless, usually 10-30%  
• HCR/HFA |
| Low-Income Housing Lotteries | • Completed application and enter it in an apartment lottery via the development/project  
• NYS- HCR; NYC – HDC |
## Affordable Housing

<table>
<thead>
<tr>
<th>Program</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Senior Citizen Rent Increase Exemption Program (SCRIE)** | • Exempts low-income renters who are 62 or older from some or all rent increases.  
• Elderly persons living in Mitchell-Lama housing, Article XI cooperatives, federally assisted cooperatives, or rent regulated apartments may be eligible  
• NYS - HCR; NYC – NYC Dept. of Aging                                                                 |
| **Disability Rent Increase Exemption (DRIE)**   | • Offers qualifying tenants with disabilities an exemption from future rent increases  
• Eligible persons must be at least 18, receive either SSI, SSDI, VA disability pension, or disability-related Medicaid, living in Mitchell-Lama housing, Article XI cooperatives, federally assisted cooperatives, or rent-regulated apartments  
• NYS – HCR; NYC - Applications can be mailed to NYC Finance Dept, SCRIE/DRIE Walk-In Center, on online |
| **Home Ownership (Mitchell-Lama)**             | • Affordable rental and cooperative housing to moderate and middle-income families  
• Income requirements set by each development  
• HCR for lists, apply directly to development                                                                 |

## Supportive Housing

<table>
<thead>
<tr>
<th>Type</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Shelter + Care**                        | • Provides rental assistance with supportive services for homeless and disabled persons and their families.  
• For homeless persons with disabilities, (SMI, SUD, AIDS or related diseases) and their families who are living in places not intended for human habitation  
• NYS – OMH, OASAS, local housing authorities/ non-profits; NYC – HPD                                                                 |
| **Mental Illness**                        |                                                                                                                                          |
| **Supported /Single Room Occupancy**       | • Permanent housing in SRO buildings. Chronically homeless single adults diagnosed with SPMI or diagnosed as mentally ill and may also have chemical addictions (MICA).  
• NYC – DOHMH, DHS, HASA; OMH  
• NYS – OMH; NYC – HRA 2010e applications required for special needs tenants only                                                                 |
| **Supported (Scattered-site)**             | • Permanent, independent level of housing. Clients pay 30% of their income towards rent and utilities and hold own lease or provider’s sublease  
• OMH                                                                 |
## Housing Categories In New York

### Supportive Housing

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>Medicaid Redesign Team (MRT)</th>
<th>NY/NY I, II</th>
<th>NY/NY III (Scattered-site &amp; Congregate)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For single adults with SMI and/or substance abuse problem who are high cost Medicaid recipients.</td>
<td>Affordable housing tied with supportive services for SPMI, street or shelter homeless</td>
<td>Affordable housing tied with supportive services; Populations A-D Chronically homeless, at-risk of homelessness and SMI</td>
</tr>
<tr>
<td></td>
<td>NYS – SPOA; NYC – HRA 2010e</td>
<td>NYC – HRA 2010e</td>
<td>NYC – HRA 2010e</td>
</tr>
</tbody>
</table>

### Substance Abuse

<table>
<thead>
<tr>
<th>Substance Abuse</th>
<th>MRT (Scattered site)</th>
<th>Re-Entry PSH Initiative (scattered-site)</th>
<th>Shelter + Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For single adults who are chronically addicted and homeless; OR at risk of homelessness and are high-cost Medicaid recipients.</td>
<td>Provides rental subsidies up to Fair Market Rental rates, case management, job development and job counseling services to parolees returning to their communities.</td>
<td>Provides rental assistance with supportive services for homeless and disabled persons and their families.</td>
</tr>
<tr>
<td></td>
<td>NYS - Any existing referral process (e.g. DSS, OASAS-funded providers, Shelters, CoC, etc.) and Health Homes; NYC – HPD, DHS</td>
<td>Eligible person must have substance abuse problems and being released on parole to NYC and would be functionally homeless if not placed in this PSH program.</td>
<td>For homeless persons with disabilities, (SMI, SUD, AIDS or related diseases) and their families who are living in places not intended for human habitation</td>
</tr>
<tr>
<td></td>
<td>NYC only – OASAS</td>
<td>NYC only – OASAS</td>
<td>OASAS, OMH, local housing authorities/non-profits; NYC – HPD</td>
</tr>
</tbody>
</table>
## Supportive Housing

### Substance Abuse

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| **NY/NY III**  | For chronically homeless single adults who have substance abuse disorder that is primary barrier to independent living and who also have a disabling clinical condition (non-SPMI) that further impairs their ability to live independently.  
- NYC – HRA 2010e |

### HIV/AIDS

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| **HOPWA**      | Housing Opportunities for Persons with AIDS (HOPWA): provides housing assistance and related supportive services for low-income (at/ below 80% AMI) persons living with HIV/AIDS (PLWHA) and their families.  
- NYS – OTDA or Eligible Metropolitan Statistical Areas (EMSA’s); NYC – DOHMH, HASA |

| **HIV/AIDS**   | 18 housing providers statewide (3 in Capital District/ North Country region) are funded to deliver one or more of the following enhanced supported housing services: rental subsidy, emergency financial assistance, independent living skills development, non-intensive case management, psychosocial support services, supportive housing coordination and housing placement and referral services.  
- For homeless individuals living with HIV/AIDS or homeless families that include individuals living with HIV/AIDS, at risk of losing housing or significantly challenged to remain in housing. |
## Housing Categories In New York

### Supportive Housing

| HIV/AIDS               | NY/NY III (Congregate)                                      | Population G: for chronically homeless families or families at risk of chronic homelessness in NYC in which the head of household has HIV/AIDS  
|                       | • Population H: for chronically homeless single adults who are living with HIV/AIDS (clients of HASA) and suffer from co-occurring SMI, SUD, or a MICA disorder  
|                       | • Homeless individuals diagnosed with clinical symptomatic HIV (AIDS Institute), or AIDS (CDC) or homeless families that include individuals living with HIV/AIDS.  
|                       | • NYC – HRA 2010e   
|                       | NY/NY III (Scattered-site & Congregate)                                        |
|                       | HASA                                                               |

### Physical / Developmental Disabilities

| Sect. 811 | • Allows persons with disabilities to live as independently as possible with rental assistance  
| MRT       | • Community-based units for people with developmental disabilities currently living in certified settings into more independent, less restrictive housing options.  
|           | • HUD                                                              |
| MRT       | • Housing subsidy for individuals able to live independently, apply 30% of income toward housing costs prior to making a request for subsidy.  
|           | • OPWDD                                                            |
| CSS       | • Subsidy based on an individual’s income and Housing and Community Renewal (HCR) payment standards. Historically, assisted adults with DD who wish to live independently by providing funds to pay for housing costs, and on a limited basis, for such things as food, transportation and clothing  
| ISS       | • OPWDD                                                            |
## Supportive Housing

### Veterans

**HUD VASH**
- Permanent housing via “Housing Choice” Section 8 vouchers for eligible homeless single Veterans or eligible homeless Veterans with families. Clinical and supportive services provided through VA. Vets must meet McKinney Act “homelessness” definition. Restrictions based on discharge status.
- To apply contact local VA Homeless Program. Vets can contact HUD-VASH program directly, or obtain a referral.

**Supportive Services for Veteran Families Program (SSVF)**
- Short-term rapid rehousing and homeless prevention services to homeless and at-risk Veterans and their families.
- VA, non-profit, CBOs

### Elderly

**Sect. 202**
- Supportive Housing for the Elderly program (Section 202) provides rent subsidies to make units affordable.
- Available for very low-income household comprised of at least one person who is at least 62 years old.
- NYC – DFTA

---

## Understanding Supportive Housing
Dimensions of Quality

Tenant-Centered
Sustainable
Accessible
Integrated
Coordinated

Defining Supportive Housing

Targets households with barriers
Is affordable
Provides tenants with leases
Engages tenants in voluntary services
Coordinates among key partners
Connects tenants with community
1. Targets Households with Barriers

- Are chronically homeless.
- Cycle through institutional and emergency systems and are at risk of long-term homelessness.
- Are being discharged from institutions and systems of care.
- Without housing, cannot access and make effective use of treatment and supportive services.

2. Housing is Affordable

Whenever possible, adequate financing is secured to allow tenant’s payment for rent and utilities to be no more than 30% of tenant income.
3. Provides Tenants with Leases

4. Tenant-Centered Service Design

What do we know about our prospective tenants and their needs?

What do prospective tenants say that they need?
Supportive Services

Health/Mental Health Services

Child Care

Employment Services and Support

Budgeting & Financial Management Training

Independent Living Skills

Community Building Activities

Substance Abuse

Why are Services Important?

Affordable Housing + Supportive Services

Platform

Health, Recovery and Personal Growth
Voluntary Services

Participation in services is not a condition of tenancy

Services are voluntary for tenants...not staff
Staff must work to build relationships with tenants

Emphasis should be on user-friendly services driven by tenant needs and individual goals

Does Voluntary Work?

Low Demand

High Rate of Housing Stability
5. Coordinates Among Key Partners

Property/Housing Management Staff + Supportive Services Providers = Tenants sustain stable housing

6. Connects tenants with community

- Units are located within safe neighborhoods with close proximity to:
  - Transportation
  - Employment opportunities
  - Services
  - Shopping, recreation and socialization

- Staff supports tenants in developing and strengthening connections to their community
Core Outcomes for Tenants in SH

Positive Supportive Housing Outcomes

- Tenants Stay Housed
- Tenants are satisfied with the services and housing
- Tenants improve their physical and behavioral health
- Tenants increase their income and employment
- Tenants have social and community connections

Understanding Health Homes
Health Homes Defined

- **Authorized under the Patient Protection & Affordable Care Act (ACA) of 2010**
  - Optional State Plan benefit authorized under Section 2703 of ACA

- **Health Home - care management model**
  - Provides enhanced care coordination and integration of primary, acute, behavioral health (mental health and substance abuse) services
  - Linkages to long-term care community services
  - Supports, social services, and family services for persons with chronic conditions
  - “whole-person” and “person-centered”
  - Integrates a care philosophy that includes both physical/behavioral care and family and social supports

Who Is Eligible for a Health Home in New York?

- **To be eligible for New York’s Health Home Program a person must be enrolled in Medicaid and have:**
  - Two chronic conditions or
  - One single qualifying condition of
    - HIV/AIDS or
    - Serious Mental Illness (SMI)

Chronic Conditions include (but are not limited to):
- Alcohol and Substance Abuse
- Mental Health Condition
- Cardiovascular Disease (e.g., Hypertension)
- Metabolic Disease (e.g., Diabetes)
- Respiratory Disease (e.g., Asthma)

- **Persons meeting the criteria above must also be appropriate for Health Home care management**
  - I.e., the person has significant behavioral, medical or social risk factors and can benefit from comprehensive care management services
Core Requirements of Health Homes

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Individual & Family Support
- Referral to Community & Social Support Services
- Use of HIT to Link Services

New York State’s Health Home Model

- There are 34 organizations operating 48 Health Homes in NYS
  [www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/]
- Health Homes establish a network of providers
- Health Home network of partners includes:
  - Health Home Care Coordinators (or care manager)
    - Connections with Mental Health/HIV/AIDS/Chronic Illness/Addiction Care Management programs
  - One or more hospital systems
  - Multiple ambulatory care sites with both physical, mental health and substance abuse specialization
  - Community based organizations, including housing providers
  - Managed care plans
New York State Health Home Model

Managed Care Organizations (MCOs)

New York State Designated Lead Health Home
Administrative Services, Network Management, HIT Support/Data Exchange

Required Health Home
Care Management Network Partners
(TCM Providers, MH, SA, HIV, Primary Care, Housing)

Comprehensive Care Management
Care Coordination and Health Promotion
Comprehensive Transitional Care
Individual and Family Support
Referral to Community and Social Support Services
Use of Health Information Technology to Link Services (Electronic Care Management Records)

Access to Required Primary and Specialty Services
(Coordinated with MCO) and Community Supports
Physical Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS,
Supportive Housing, Social Services and Supports

Coordinating Care: Health Homes & Supportive Housing
**Health Home Model w/ Supportive Housing Needs**

- **Physical Health/ Specialty Physician**
- **Payer/MCOs**
- **Homeless Shelter**
- **Correctional Services**
- **Supportive Housing**
- **Peer Advocacy**
- **Dept. of Social Services**
- **Behavioral Health Services**
- **Transportation**
- **Pharmacy**
- **Legal Services**
- **Home Care**

**Example:** Health Home Client with Behavioral Health Needs

---

**HH Care Coordinators & SH Case Managers**

- Health Home Care Coordinator *coordinates* services to be received
- Supportive Housing Case Managers *provide* and *coordinate* direct services

---

**Coordinates services**

**Provides & coordinates services**

---

**HH Care Coordinator**

**SH Case Manager**
Integrating SH & HH Services

Health Home Care Coordinator

*Overarching Goal:*

Ensure optimal health outcomes

Supportive Housing Case Manager

*Overarching Goal:*

Ensure housing stability

Collaborative relationship with defined roles and shared tasks that serve the best interest of the client/tenant to ensure optimal health & social outcomes (roles may vary depending on needs of client/tenant)

What’s Been Working For You

<table>
<thead>
<tr>
<th>Care Activity</th>
<th>Defining Roles and Collaborating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess Eligibility for Health Home</td>
<td>HH Care Coordinator (HHCC)</td>
</tr>
<tr>
<td>Enroll client in Health Home</td>
<td>SH Case Manager (SHCM)</td>
</tr>
<tr>
<td>Identify Appropriate Housing and Availability</td>
<td>Collaboration between HHCC &amp; SHCM</td>
</tr>
<tr>
<td>Submit Housing Applications; sends approved application to Housing providers</td>
<td></td>
</tr>
<tr>
<td>Coordinate admission into appropriate housing</td>
<td></td>
</tr>
<tr>
<td>Develop coordinated plan of care</td>
<td></td>
</tr>
<tr>
<td>Assist tenant in identifying and achieving recovery and other goals consistent with care plan</td>
<td></td>
</tr>
<tr>
<td>Assist with socialization and recreational activities</td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td></td>
</tr>
<tr>
<td>Helps to mitigate landlord issues/disputes</td>
<td></td>
</tr>
</tbody>
</table>
New York State Agencies Panel

- Elizabeth Misa, Deputy Director of NYS Medicaid, Office of Health Insurance Program (DOH)
- Raná Meehan, Mental Health Program Specialist, (OMH)
- Barry Kinlan, Housing and Data Coordinator, Health Home Program (DOH)
- Cindy Brownell, Manager, Housing Program Unit, AIDS Institute
- Judy Monson, Addictions Program Specialist 2, Bureau of Housing (OASAS)
- Kerri Neifeld, Excelsior Fellow- Center for Specialized Services (OTDA)
- Vivian Street, Rockland County Community Support Team Leader, Housing Coordinator for Region 3, Hudson Valley DDRO (OPWDD)
- Lisa Irizarry, Director of Special Needs Housing, NYS Homes and Community Renewal (HCR)
AGENDA

Overview of MRT Supportive Housing Units
- What is MRT supportive housing?
- What populations are served?
- What resources are available?

Housing is Health Care
- Addressing the Social Determinants of Health
- Link high-cost Medicaid members with housing
  - Bend the Medicaid cost curve
  - Improve quality of care for high-cost Medicaid members
MRT SUPPORTIVE HOUSING COMPONENTS

- Capital
- Rent
- Support Services

Footnote: Costs for supportive housing provided by the Supportive Housing Network of New York and based on average yearly estimates of $14,000-$35,000 for non-acute supportive housing in New York City. Most costs for supportive housing are approximately $15,000-$20,000 per year. Hospitalization, nursing home, emergency department, and detoxification costs represent average 2012 fee-for-service Medicaid payments in New York.
MRT Supportive Housing Populations

- High-Cost Medicaid Members
- Individuals transitioning out of nursing homes
- Chronically Homeless with HIV/AIDS, Mental Health and/or Substance Use Disorders
- Chronically Addicted Homeless or at risk of homelessness
- Physically Disabled Homeless
- Seniors in need of supportive housing in the community
- Developmentally Disabled
- Seniors in Shelter or low-income seniors in the community
- Physically Disabled Homeless

MRT SUPPORTIVE HOUSING RESOURCES

- $222 million over two years (in 2014-15 and 2015-16)
  - Capital
  - Rental and Service Supports
  - Pilot Projects

<table>
<thead>
<tr>
<th>Pilot Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Homes Supportive Housing Pilot</td>
</tr>
<tr>
<td>Step-Down/Crisis Residence Capital Conversion</td>
</tr>
<tr>
<td>Nursing Home to Independent Living Rapid Transition</td>
</tr>
<tr>
<td>OMH Supported Housing Services Supplement</td>
</tr>
<tr>
<td>Homeless Senior Placement Pilot Project</td>
</tr>
<tr>
<td>Health Home HIV + Rental Assistance Pilot Project</td>
</tr>
<tr>
<td>Senior Supportive Housing Pilot Project</td>
</tr>
</tbody>
</table>
TRACKING AND EVALUATION

• All individuals will be tracked
• Analyze pre and post Medicaid spending
• Partnering with researchers
• Robust tracking and evaluation
• Short Term and Long Term Results

To learn more about MRT Supportive Housing, please visit our website at:

http://www.health.ny.gov/health_care/medicaid/redesign/affordable_housing_workgroup.htm
DOH North Country/ Capital District
Health Home Contacts

1. Adirondack Health Institute, Inc.
   Main Contact: Annette Parisi 518-761-0300 Ext. 31578,
aparisi@adkhealth.com
   Referral Contact: Annette Parisi 518-761-0300 Ext. 31578,
aparisi@adkhealth.com
   Member Referral Number: 1-866-708-2912

2. Capital Region Health Connections (Samaritan Hospital)
   Counties: Albany, Rensselaer
   Main Contact: Rachel Handler 518-271-3188, Rachel.Handler@sphp.com
   Referral Contact: Roxanne Health 518-271-3473,
   RoxanneEk@vnshomecare.org
   Referral Number: 1-518-353-4482 or 518-371-3301

3. Glens Falls Hospital
   Main Contact: Tracy Mills 518-926-6998, tmills@glensfallshosp.org
   Alternate Contact: Joanne DeWeese 518-926-7240 ext. 403,
   jdwesee@glensfallshosp.org
   Referral Contact: Joanne DeWeese 518-926-7240 ext 403,
   jdwessee@glensfallshosp.org
   Referral Contact: Jessica Schwartzman 518-926-9529
   jlschwa@glensfallshosp.org
   Member Referral Number: 1-855-414-4663

4. Hudson River Healthcare, Inc.
   Counties: Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Suffolk, Sullivan, Westchester
   Main Contact: Allison McGuire 914-734-8543,
amcguire@brhhealthcare.com
   Main Contact: Katie Clay 914-734-8513,
kclay@brhhealthcare.com
   Member Referral Number: 1-888-980-8410

5. St. Mary’s Healthcare
   Counties: Fulton, Montgomery
   Main Contact: Brenda Maynor 518-841-3986, Brenda.maynor@smha.org
   Alternate Contact: Heather Clear-Rouzbakh 518-773-3531 ext.4116,
   Clear_rouzbakh@smha.org
   Referral Contact: Devin Smullen 518-773-3531 ext. 4747,
   Devin.smullen@smha.org
   Referral Contact: Heather Clear-Rouzbakh 518-773-3531 x4116,
   Clear_rouzbakh@smha.org

6. Visiting Nurse Service of Schenectady and Saratoga Counties, Inc.
   Counties: Saratoga, Schenectady
   Main Contact: Joseph Twarody 518-382-8050 ext. 211,
   twarody@vnshomecare.org
   Alternate Contact: Timothy Berger 518-382-7932,
   timothyberger@vnshomecare.org
   Alternate Contact: Donna Jennings 518-243-4695,
   jenningsd@vnshomecare.org
   Referral Contact: Donna Jennings 518-243-4695,
   jenningsd@vnshomecare.org
   Member Referral Line: 1-855-204-0088

---

Central New York Region
Health Home Contacts

1. Catholic Charities of Broome County
   Counties: Broome
   Main Contact: Julie Smith (607) 723-9991 Ext. 224, jsmith@cccb.net
   Referral Contact: Gary Tucker (607) 723-9991 Ext. 317, gtucker@cccb.net
   Referral Contact: Barbara Marks (607) 723-9991 Ext. 427,
   bmarks@cccb.net

2. Central New York Health Network, Inc.
   Counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence
   Main Contact: Laura Eannace (315) 724-6907 Ext. 2303,
   laura.eannace@cnnyhealthhome.net
   Alternate Contact: Kim Pecor (315) 266-0627 Ext. 309,
   Kimberly.pecor@cnnyhealthhome.net
   Referral Contact: Carleen Stewart (315) 266-0627 Ext. 226,
   carleestewart@cnnyhealthhome.net
   Referral Contact: Lea Tolman (315) 266-0627 Ext. 312,
   lotolman@cnnyhealthhome.net
   Referral Contact: Betty Weaver (315) 266-0627,
   betweaver@cnnyhealthhome.net

3. The Mary Imogene Bassett Hospital
   Counties: Chenango, Delaware, Otsego, Schoharie
   Main Contact: Ann Hutchinson (607) 212-2594,
   Ann.Hutchinson@Bassett.org

4. Onondaga Case Management Services, Inc.
   Counties: Cayuga, Cortland, Madison, Onondaga, Oswego, Tioga, Tompkins. Chemung
   Main Contact: Joseph Twarody 518-382-8050 ext. 211,
   twarody@vnshomecare.org
   Main Contact: John Lee (585) 613-7642,
   John.Lee@beaconhs.com
   Referral Contact: Tracy Marchese (585) 613-7642,
   tracy.marchese@beaconhs.com

5. St. Joseph’s Care Coordination Network (SJCCN)
   Counties: Cayuga, Madison, Onondaga, Oswego
   Main Contact: Kristen Muczelli-Heath (315) 744-1383,
   kristen.heath@sjhsyr.org
   Referral Contact: Dyana Morrow (315) 703-2768,
   Dyana.Morrow@sjhsyr.org
   Referral Contact: Eric Stone (315) 703-2802,
   Eric.Stone@sjhsyr.org

6. United Health Services Hospitals
   Counties: Broome
   Main Contact: Robin Kinslow-Evans (607) 762-2801,
   robin_kinslow-evans@ushs.org
   Referral Contact: Anne Bishop (607) 762-2862,
   Anne_Bishop@ushs.org

---

* For other Health Home Contact Information visit
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm
New York City Downstate Health Home Contacts

BRONX
1. Bronx Lebanon Hospital Center
Main Contact: Virginia González 718-901-8927, vgonzale@bronxleb.org
Alternate Contact: Amanda Semides, 212-590-2574, asemides@rcbicare.org
Referral Contact: Virginia González 718-901-8927, vgonzale@bronxleb.org
Member Referral Line: 855-866-9432

2. Bronx Accountable Healthcare Network Health Home (BAHN)
Main Contact: Nicole Jordan-Martin 914-378-6151, njordan@montefiore.org
Referral Contact: Olbi Ijepeze 914-378-6151, oijkepez@montefiore.org
Referral Contact: Jacqueline Santiago 914-378-6151, jscantis@montefiore.org

3. Community Care Management Partners (CCMP), LLC (Visiting Nurse Service of New York Home Care)
Main Contact: Alyssa Lord 212-216-9911, alyssa.lord@vnsny.org
Alternative Contact: Phil Opatz 212-290-6467, phil.opatz@vnsny.org
Referral Contact: Alyssa Lord 212-216-9911, alyssa.lord@vnsny.org

4. Community Health Care Network (Queens Coordinated Care Partners)
Main Contact: Rosemary Cabrera 212-545-2469, rosemaryc@chcnyc.org
Main Contact: Elizabeth Malavé 212-545-6206, emalave@chcnyc.org
Alternate Contact: Ryan Wilcoxson 212-545-6211, rwilcoxson@chcnyc.org
Alternate Contact: Cady Herman 646-477-2833, caherman@chcnyc.org
Member Referral Number (Brooklyn): 1-855-CHN-HHCC (1-855-246-4422)
Member Referral Number (Queens): 1-855-CHN-HH01 (1-855-246-4401)

5. New York City Health and Hospitals Corporation
Main Contact: Dr. Deborah Rose 212-788-2455; deborah.rose@nychhc.org
Referral kenza Martin 212-788-5437; kenza.martin@nychhc.org
Member Referral Line: 1-855-602-4663

New York City Downstate Health Home Contacts

MANHATTAN
1. Community Care Management Partners (CCMP), LLC (Visiting Nurse Service of New York Home Care)
Main Contact: Alyssa Lord 212-216-9911, alyssa.lord@vnsny.org
Alternative Contact: Phil Opatz 212-290-6467, phil.opatz@vnsny.org
Referral Contact: Alyssa Lord 212-216-9911, alyssa.lord@vnsny.org

2. Continuum Health Home Network (St. Luke’s-Roosevelt Hospital Center)
Main Contact: Miriam Martinez 212-523-2025, mimartinez@chpnyc.org
Referral Contact: Kristina Monti 212-523-5002, KMonti@chpnyc.org

3. Heritage Health and Housing Network: Heritage Health Home Network (Heritage Health and Housing Inc., Northern Manhattan Health Home Network Inc.)
Main Contact: LaQuita Henry 212-866-2600 ext 1148, lhumphrey@heritageny.org
Alternate Contact: Fred Humphrey 212-866-2600 ext 1364, lhumphrey@heritageny.org
Referral Contact: LaQuita Henry 212-866-2600 ext 1148, lhumphrey@heritageny.org
Referral Contact: Dr. Alvaro Simmons 212-862-0054 ext 1148, asimmons@heritageny.org

4. Coordinated Behavioral Care, Inc
Main Contact: Inna Borod 212-590-2573 iborod@cbcare.org
Main Contact: Danika Mills 212-590-2407, dmills@cbcare.org
Referral Contact: Rosemarie Almendares 212-590-2406, balmendares@cbcare.org
Member Referral Line: 866-899-0152

5. New York City Health and Hospitals Corporation
Main Contact: Dr. Deborah Rose 212-788-2455; deborah.rose@nychhc.org
Referral kenza Martin 212-788-5437; kenza.martin@nychhc.org
Member Referral Line: 1-855-602-4663

6. The New York and Presbyterian Hospital
Main Contact: Victor Curlis 212-342-0236, vac9009@nyp.org
Referral Contact: Peggy Chao 212-342-0274, pchao@nyp.org
Referral Contact: Victor Curlis 212-342-0196, vac9009@nyp.org

RICHMOND (STATEN ISLAND)
1. Coordinated Behavioral Care, Inc
Main Contact: Inna Borod 212-590-2573 iborod@cbcare.org
Main Contact: Danika Mills 212-590-2407, dmills@cbcare.org
Referral Contact: Rosemarie Almendares 212-590-2406, balmendares@cbcare.org
Member Referral Line: 866-899-0152

* For other Health Home Contact Information visit
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm
Queens
1. North Shore LIJ Health Home
Main Contact: Irina Mitzer (516) 876-6778, IMitzer@nshs.edu

2. Community Health Care Network (Queens Coordinated Care Partners)
Main Contact: Rosemary Cabrera 212-545-2469, rcabrera@chnyc.org
Main Contact: Elizabeth Malavé 212-545-6206, emalave@chnyc.org
Alternate Contact: Ryan Wilcoxson 212-545-6211, rwilcoxson@chnyc.org
Alternate Contact: Cady Herman 646-477-2833, CadyHerman@chnyc.org
Member Referral Number (Brooklyn): 1-855-CHN-HHCC (1-855-246-4422)
Member Referral Number (Queens): 1-855-CHN-HH01 (1-855-246-4401)

3. New York City Health and Hospitals Corporation
Main contact: Dr. Deborah Rose 212-788-2455, deborah.rose@nychhc.org
Referral contact: Kenza Martin 212-788-5437, kenza.martin@nychhc.org
Referral Contact: Anna Borik 212-590-2573, aborik@cbbc.org
Main Contact: Danika Mills 212-590-2407, dmills@cbbc.org
Referral Contact: Berenice Almendariz 212-590-2406, balmendariz@cbbc.org
Member Referral Line: 1-855-602-4663

Long Island - Nassau and Suffolk
1. FECS Health & Human Services System
Main Contact: Sue McKenna 516-505-2003 x 312285, smckenna@feecs.org
Main Contact: Melissa Firmes 631-691-7080 x 332238, sfirmes@feecs.org
Alternate Contact: Steve Rutter 516-505-2003 x 312211, srutter@feecs.org
Alternate Contact: Allegra D’Allo 516-505-2003 x 312342, adallo@feecs.org
Referral Contact: Gina Laserra 631-691-7080 x 332390, glaserra@feecs.org
Member Referral Number (Nassau): 855-544-8484
Member Referral Number (Suffolk): 855-838-0621

2. North Shore LIJ Health Home
Main Contact: Irina Mitzer (516) 876-6778, IMitzer@nshs.edu

3. Hudson River Healthcare (DBA) Community Health Care Collaborative (CCC)
Main Contact: Allison McGuire 914-734-8543, amguire@hrhcare.org
Main Contact: Katie Clay 914-734-8513, kclay@hrhcare.org
Member Referral Number: 1-888-980-8725

Brooklyn
1. Community Health Care Network (Queens Coordinated Care Partners)
Main Contact: Rosemary Cabrera 212-545-2469, rcabrera@chnyc.org
Main Contact: Elizabeth Malavé 212-545-6206, emalave@chnyc.org
Alternate Contact: Ryan Wilcoxson 212-545-6211, rwilcoxson@chnyc.org
Alternate Contact: Cady Herman 646-477-2833, CadyHerman@chnyc.org
Member Referral Number (Brooklyn): 1-855-CHN-HHCC (1-855-246-4422)
Member Referral Number (Queens): 1-855-CHN-HH01 (1-855-246-4401)

2. Coordinated Behavioral Care, Inc
Main Contact: Inna Borik 212-590-2573, iborik@cbbc.org
Main Contact: Danika Mills 212-590-2407, dmills@cbbc.org
Referral Contact: Berenice Almendariz 212-590-2406, balmendariz@cbbc.org
Member Referral Line: 866-899-0152

• For other Health Home Contact Information visit http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm
Hudson Valley Region  
Health Home Contacts

1. Community Health Care Collaborative (CCC)  
Counties: Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Suffolk, Sullivan, Westchester  
Main Contact: Allison McGuire (914) 734-8543, amcguire@hrhcare.org  
Main Contact: Kathleen Clay (914) 734-8513, kclay@hrhcare.org  
Member Referrals: 1-888-980-8410

2. Hudson Valley Care Coalition  
Counties: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester  
Main Contact: Gladys Johnson (914) 372-2374, gjohnson@hcheq.org  
Alternate Contact: Lena Johnson (914) 606-3305, lena.Johnson@hcheq.org

3. Institute for Family Health  
Counties: Ulster  
Main Contact: Virna Little (347) 203-8856, Vlilittle@institute2000.org  
Referral Contact: Melissa Martinez (877) 207-3387, mmartinez@institute2000.org  
Referral Contact: Carmen Beltre (212) 633-0800 Ext. 1345, cbeltre@institute2000.org

* For other Health Home Contact Information visit  
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm

Western New York Region  
Health Home Contacts

1. Chautauqua County Department of Mental Hygiene  
Counties: Allegany, Cattaraugus, Chautauqua  
Main Contact: Adele Gorges (585) 613-7656, asorges@ccsi.org  
Main Contact: John Lee (585) 613-7642, johnLee@beaconhs.com  
Referral Contact: Tracy Marchese (585) 613-7642, tracy.marchese@beaconhs.com

2. Greater Buffalo United Accountable Healthcare Network-GBUahn  
Counties: Erie  
Main Contact: Raul Vazquez (716) 830-4840, ravazquez@gbuahn.org  
Main Contact: Momba Chia (716) 247-5282 Ext. 230, monba.chia@gbuahn.org  
Alternate Contact: Kirsten Newby (716) 247-5282 Ext. 218, kirsten.newby@buffalo.edu  
Alternate Contact: Lau Santiago (716) 628-1674, lousantiago1@gmail.com  
Member Referral Number: (716) 247-5282 – ask for Member Services

3. Greater Rochester Health Home Network  
Counties: Monroe  
Main Contact: Deborah Peartree (585) 737-7522; rihv@Rochester.rr.com  
Referral Contact: Deborah Peartree (585) 737-7522; rihv@Rochester.rr.com

4. Health Home Partners of Western New York  
Counties: Erie, Niagara, Wyoming  
Main Contact: Bruce Niblet (716) 662-2040, nibletb@shswny.org  
Referral Contact: Christopher Hartnett (716) 539-1794, healthnet@shswny.org  
Referral Contact: Amy Ditta (716) 539-1762, ditta@shswny.org

* For other Health Home Contact Information visit  
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm
Western New York Region
Health Home Contacts

5. Health Homes of Upstate New York (HHUNY)
Counties: Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates, Genesee, Orleans
Main Contact: Adele Gorges (585) 613-7656, agorges@ccsi.org
Main Contact: John Lee (585) 613-7642,
John.Lee@beaconhs.com
Referral Contact: Tracy Marchese (585) 613-7642,
tracy.marchese@beaconhs.com

6. Niagara Falls Memorial Medical Center
Counties: Niagara
Main Contact: Sheila Kee (716) 278-4301,
Sheila.Kee@nfmmc.org
Main Contact: Vicki Landes (716) 278-4647,
Vicki.Landes@nfmmc.org

7. Onondaga Case Management Services, Inc.
Counties: Cayuga, Cortland, Madison, Onondaga, Oswego,
Tioga, Tompkins, Chemung
Main Contact: Adele Gorges (585) 613-7656, agorges@ccsi.org
Main Contact: John Lee (585) 613-7642,
John.Lee@beaconhs.com
Referral Contact: Tracy Marchese (585) 613-7642,
tracy.marchese@beaconhs.com

• For other Health Home Contact Information visit
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm

NYS Office of Mental Health

OMH REGIONS

Counties within Regions
Central Region: Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Fulton, Franklin, Hamilton, Herkimer, Jefferson, Madison, Montgomery, Lewis, Oneida, Onondaga, Oswego, Otsego and St. Lawrence


Lower Hudson River Region: Dutchess, Orange, Putnam, Rockland and Westchester

Western Region: Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, and Yates

Long Island Region: Nassau and Suffolk

Counties in NYC Region: Bronx, Kings, New York, Queens and Richmond
How to Locate OMH Regional Specific Providers

All Programs Statewide:
http://bi.omh.ny.gov/bridges/index

Medicaid Redesign Team Affordable Housing Units Central New York Region:

OMH Bureau of Housing Development and Support

Moira Tashjian, Director
518 474-5191
Moira.tashjian@omh.ny.gov
Or
Raná Meehan, Mental Health Program Specialist
518 474-5191
Rana.Meehan@omh.ny.gov
1. Community Health Care Collaborative (CCC)
   Counties: Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Suffolk, Sullivan, Westchester
   Main Contact: Allison McGuire (914) 734-8543, amcguire@hrhcare.org
   Main Contact: Kathleen Clay (914) 734-8513, kclay@hrhcare.org
   Member Referrals: 1-888-980-8410

2. Hudson Valley Care Coalition
   Counties: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
   Main Contact: Gladys Johnson (914) 372-2374, gjohnson@hcheq.org
   Alternate Contact: Lena Johnson (914) 606-3305, lena.johnson@hcheq.org

3. Institute for Family Health
   Counties: Ulster
   Main Contact: Virna Little (347) 203-8856, vlittle@institute2000.org
   Referral Contact: Melissa Martinez (877) 207-3387, mmartinez@institute2000.org
   Referral Contact: Carmen Beltre (212) 633-0800 Ext. 1345, cbeltre@institute2000.org

For other Health Home Contact Information visit http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm
Housing and Supportive Housing Services in the Capital Region

- The NYS Department of Health AIDS Institute funds 3 providers in the Capital Region for Supportive Housing services
- Funded providers include: AIDS Council of Northeastern New York, Catholic Charities Community AIDS Services and Unity House of Troy
- Services include: Long Term Rental Assistance & Housing Retention Services (MRT), Financial Assistance & Enhanced Supportive Housing Services

Housing and Supportive Housing Services in the Hudson Valley

The NYS Department of Health AIDS Institute funds 3 providers in the Hudson Valley region
- Funded providers include: Family Services of Westchester, Hudson Valley Community Services and Pathstone Corporation
- Services include: Financial Assistance and Enhanced Supportive Housing Services
The NYS Department of Health AIDS Institute funds 3 providers in Central New York and 1 provider in the Southern Tier Region for Supportive Housing services

- Funded providers include: ACR Health, Central NY Health Systems Agency, Liberty Resources, Inc. and Southern Tier AIDS Program
- Services include: Long Term Rental Assistance & Housing Retention Services (MRT), Financial Assistance & Enhanced Supportive Housing Services

Eligibility Criteria:

- Individual must be:
  - HIV positive
  - Homeless, unstably housed or at risk of losing housing

*Some of the funding has income & Medicaid/Health Home eligibility requirements. There may also be other agency specific eligibility requirements.*
Financial Assistance

**Emergency Rental Assistance:**
- One-time only financial assistance for eligible consumers in danger of eviction or foreclosure, or to assist in obtaining alternate housing. Costs may include first month rent or rental arrears.

**Emergency Utility Assistance:**
- One-time only financial assistance for eligible consumers in order to avoid utility shut off. Costs may include utilities such as gas, oil, water, electric, and basic monthly telephone.

**Security Deposit:**
- One-time only financial assistance to pay for eligible consumers’ security deposit for discrete residence. Security deposits may include first and last month’s rent.

**Moving Expenses:**
- One-time only financial assistance to pay for eligible consumers’ moving costs when the move occurs within the provider agency’s catchment area from one residence to another residence.

**Broker Fees:**
- One-time only financial assistance to pay for eligible consumers’ housing locator or realty (broker’s) fees.

**Minor Renovations (Non-Permanent):**
- One-time only financial assistance for eligible consumers to pay for non-permanent fixtures such as handrails, ramps, or security measures.

Financial Assistance (cont’d)
Financial Assistance (cont’d)

**Short-Term Rental Assistance:**
- Short-term rental assistance provides financial support for clients in transitional housing to enable the individual and/or family to gain and/or maintain medical care. Short-term rental assistance provides financial assistance to pay for a portion of an eligible consumer’s rent for multiple periods, unlike emergency financial assistance. Short-term rental assistance is intended to be available up to 24 months (or longer when a provider can justify the delay in securing permanent housing).

**Short-Term Utility Assistance/Subsidy:**
- Short-term utility assistance provides support for clients in transitional housing to enable the individual and/or family to gain and/or maintain medical care. Short-term utility assistance provides financial assistance for eligible consumers’ utilities for multiple periods. Costs may include utilities such as gas, oil, water, electric, and basic monthly telephone. Short term utility assistance is intended to be available up to 24 months (or longer when a provider can justify the delay in securing permanent housing).

Enhanced Supportive Housing Services

- Health & Independent Living Skills Development
- Housing Placement Assistance and Referral
- Psychosocial Support Services
Medicaid Redesign Team (MRT)

- Long Term Rental Subsidy
- Housing Retention Services

AIDS Institute Resources

- Housing and Supportive Housing Programs
  www.health.ny.gov/diseases/aids/general/about/housing

- AIDS Institute Resource Directory
  www.health.ny.gov/diseases/aids/general/resources/resource_directory
Cindy Brownell, Manager, Housing Programs Unit

cindy.brownell@health.ny.gov

518-474-8162
OASAS Bureau of Housing Services

Capital District/ North Country Housing Providers

**Capital District Housing Providers:**

**ALBANY**

St. Peter’s Addiction Recovery Center
35 Mercuree Lane
Guilderland, NY 12084
Patrick Carrese, Executive Director
pcarrese@sphec.org
(518) 452-6700

**ALBANY**

St. Peter’s Addiction Recovery Center
35 Mercuree Lane
Guilderland, NY 12084
Patrick Carrese, Executive Director
pcarrese@sphec.org
(518) 452-6700

**SCHENECTADY**

New Choices Recovery Center
302 State Street
Schenectady, NY 12305
Stuart I. Rosenblatt, Ph.D., Executive Director
Schoenblatt@newchoicesrecovery_center.org
(518) 482-4673

**SCHENECTADY**

New Choices Recovery Center
302 State Street
Schenectady, NY 12305
Stuart I. Rosenblatt, Ph.D., Executive Director
Schoenblatt@newchoicesrecovery_center.org
(518) 482-4673

**RENSSELAER**

Unity House of Troy
2431 Sixth Avenue
Troy, NY 12180
Christopher Burke, CEO
christopher@unityhouseoftroy.org
(518) 274-2633

**FRANKLIN**

Citizen Advocates
Beth Hospital, Director MI, CD & Community Support Services
209 Park Street
P.O. Box 608
Malone, NY 12953
beth@citizenadvocates.net
(518) 483-8980

**JEFFERSON**

Credo Community Center
595 Main Street
Watertown, NY 13601
Jim Scordo, Executive Director
dan@credocommunitycenter.org
(315) 788-1530

**ONEIDA**

Central NY Services
1411 Genesee Street
Utica, NY 13501
Johanna Williams, Program Director
jwilliams@cnyservices.org
(315) 561-8480

**Oswego County Marcy Recovery Center**

200 7th Avenue
Marcellus, NY 13108
Denise Cavanaugh, Executive Director
denise@ccharityom.org
(315) 682-2200

**Catholic Charities of Cortland County**

33 – 35 Central Avenue
Cortland, NY 13045
Marie Walsh, Executive Director – mwalsh@ccgcc.org

**Central Region Housing Providers**

**Catholic Charities of Cortland County**

33 – 35 Central Avenue
Cortland, NY 13045
Marie Walsh, Executive Director – mwalsh@ccgcc.org

**Central NY Services (Shelter Plus Care)**

1006 Park Avenue
Utica, NY 13501
Johanna Williams, Program Director – jwilliams@cnyservices.org

**Central NY Services (Medicaid Redesign (MRT) Permanent Supportive Housing (PSH))**

1411 Genesee Street
Utica, NY 13501
Johanna Williams, Program Director – jwilliams@cnyservices.org

**Credo Community Center**

595 Main Street
Watertown, NY 13601
Jim Scordo, Executive Director
dan@credocommunitycenter.org

**Liberty Resources**

1065 James Street – Suite 200
Syracuse, NY 13203
Marta Durkin, Vice President of Behavioral Healthcare – mdurkin@liberty-resources.org

**Syracuse Brick House**

329 North Salina Street
Syracuse, NY 13203
Raymond Wright, Residential Service Director – raymondw@sbh.org

Additional OASAS programs in the Capital District / North Country:

**North Country Freedom Homes**

25 Dies Street
Canton, NY 13617
Greg Aldrich, Program Director
greg@charityom.org
(2 Community Residences)

**Insight House**

500 Whitesboro Street
Utica, NY 13501
Donna Vitagliano, President
donna@insight_house.com
(2 Community Residences)

**Rescue Mission of Utica**

212 Rutgers Street
Utica, NY 13501
Rebecca King, Program Director
rebecca@charityom.org
(2 Community Residences)

**Twin Oaks**

75 Oak Street
Plattsburgh, NY 12901
Nancy Ann Price, Program Director
nard.Price@charityom.org
(2 Community Residences)

**Champlain Valley Family Center**

20 Ampersand Drive
Plattsburgh, NY 12901
Connie Wille, Director – cwille@cvfamilycenter.org

**Catholic Charities of Oneida/Madison**

1404 Genesee Street
Utica, NY 13501
Denise Cavanaugh, Executive Director – dcavanaugh@ccharityom.org
(2 Community Residences)

**Twin Oaks**

75 Oak Street
Plattsburgh, NY 12901
Nancy Ann Price, Program Director
nard.Price@charityom.org
(2 Community Residences)

**Additional OASAS programs in the Capital District / North Country:**

**North Country Freedom Homes**

25 Dies Street
Canton, NY 13617
Greg Aldrich, Program Director
greg@charityom.org
(2 Community Residences)

**Insight House**

500 Whitesboro Street
Utica, NY 13501
Donna Vitagliano, President
donna@insight_house.com
(2 Community Residences)

**Rescue Mission of Utica**

212 Rutgers Street
Utica, NY 13501
Rebecca King, Program Director
rebecca@charityom.org
(2 Community Residences)
<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Contact Person</th>
<th>Phone Number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Council on Alcoholism &amp; Drug Abuse of Sullivan County, Inc.</td>
<td>11 Hamilton Avenue</td>
<td>Izetta Briggs, Chief Executive Officer</td>
<td>(845) 794-8080</td>
<td><a href="mailto:izettabriggs@recovery-center.com">izettabriggs@recovery-center.com</a></td>
</tr>
<tr>
<td>The Guidance Center of Westchester</td>
<td>256 Washington Street</td>
<td>Rita Liegner, Deputy Dir. Rehabilitation Services</td>
<td>(914) 636-4440</td>
<td><a href="mailto:rliegner@theguidancecenter.org">rliegner@theguidancecenter.org</a></td>
</tr>
<tr>
<td>Mid-Hudson Addiction Recovery Center, Inc.</td>
<td>51 Cannon Street</td>
<td>Steven Pressman, Executive Director</td>
<td>(845) 452-8816</td>
<td><a href="mailto:spressman@csdsl.net">spressman@csdsl.net</a></td>
</tr>
<tr>
<td>Multi-County Community Development Corp.</td>
<td>Twin Maples Plaza</td>
<td>Jerry Lesczynski, Managing Director</td>
<td>(845) 247-9110</td>
<td><a href="mailto:jerryl@rehab.org">jerryl@rehab.org</a></td>
</tr>
<tr>
<td>Regional Economic Community Action Program, Inc.</td>
<td>40 Smith Street</td>
<td>Charles Darden, Executive Director</td>
<td>(845) 342-3978</td>
<td><a href="mailto:cdarden@recap.org">cdarden@recap.org</a></td>
</tr>
</tbody>
</table>

**Office of Temporary and Disability Assistance**

Local Social Services District: first stop for shelter and emergency housing needs

https://otda.ny.gov/workingfamilies/dss.asp

HUD Continuums of Care: coordinate local housing resources for homeless individuals and families, including those with disabilities

https://www.onecpd.info/grantees/?granteesaction=main.searchresults&searchText=&stateId=NY&programId=3&orgNameFirstCharacter=#alphaFacet

OTDA Programs: capital and operating funds for housing providers

https://otda.ny.gov/programs/housing/programs.asp
https://otda.ny.gov/programs/housing/providers/
Thank you.

Kristin Miller
kristin.miller@csh.org

Pascale Leone
pascale.leone@csh.org

www.csh.org