REPORT OF THE
DEPARTMENT OF SOCIAL SERVICES STUDYING

THE PROVISION OF CERTAIN SERVICES TO LOW-TO-MODERATE INCOME PERSONS ALLOWING THEM TO REMAIN IN INDEPENDENT LIVING FACILITIES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 52

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

February 12, 1996

TO: The Honorable George Allen
Governor of Virginia

and

The General Assembly of Virginia

The 1995 General Assembly, by House Joint Resolution 564, requested the Department of Social Services and the Department for the Aging to study the provision of services to low-to-moderate income persons which will allow then to remain in independent living facilities.

The enclosed report is submitted in response to the resolution.

Sincerely,

Clarence H. Carter
Acting Commissioner
Department of Social Services

Thelma Bland
Commissioner
Department for the Aging

/mae

Enclosure

PREFACE

House Joint Resolution 564 requests the Departments of Social Services and for the Aging to study the provision of services to low-to-moderate income persons which will allow them to remain in independent living facilities. The resolution specified that the study:

- consider and identify the services which are necessary to maintain older citizens in the least restrictive home setting; and
- identify a system of funding, including a sliding fee schedule, through which at-risk citizens can access these services.

This document was prepared in response to House Joint Resolution 564. The full text of the resolution is provided in Appendix A.

The Department of Social Services and the Department for the Aging formed a task force composed of individuals with professional experience and expertise in the area of senior housing to assist with the study.

Staff assigned: Joy Duke, Department of Social Services
Faye Cates, Department for the Aging

ACKNOWLEDGEMENTS

The Virginia Departments of Social Services and for the Aging conducted this study as requested in House Joint Resolution 564. A task force of individuals with professional experience and expertise in senior housing was instrumental in providing directions for the study and in formulating recommendations. Faye Cates, Virginia Department for the Aging, served as the issue expert for the study.

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EXECUTIVE SUMMARY

Concerns about residents of federal and state subsidized housing who are aging-in-place without the availability of essential services led the Virginia General Assembly to request this study. The study reviews congregate housing in Virginia, identifies the supportive services necessary to maintain older persons in the least restrictive home settings, reviews models for linking housing and services, reviews risk, examines current Virginia models which link services and housing, and identifies models for funding support services in assisted housing.

Key findings resulted from analyses of data and information compiled by the Task Force.

National Phenomena Which Impacts Service Needs in Congregate Housing

- There is an unprecedented number of elders in the population and the trend toward an older population will continue into the 21st century.

- Aging-in-place is a phenomenon in senior housing.

- Chronic disability usually means greater reliance on others to provide help with daily living activities.

Supportive Services in Virginia's Congregate Housing

- Essential supportive services commonly include, but are not limited to, assistance with: transportation, personal care, housekeeping, shopping assistance, medication reminders, and meal preparation.

Other State-Sponsored Senior Housing Initiatives

- The Virginia Housing Partnership Fund was established by the Governor and the 1988 General Assembly to support and encourage improvement of housing resources and opportunities available to lower-income Virginians.

- The Virginia Housing Partnership Fund created the Congregate Housing Program to help people with special needs live independently. The program is designed to increase the supply and improve the quality of housing available to low-and-moderate income citizens with special needs.

- The Internal Revenue Code of 1986 provides tax credits to owners of residential rental projects providing low-income housing units. This program is called the Low-Income Housing Tax Credit Program.

- The purpose of the Rent Reduction State Tax Credit Program is to increase and preserve the supply of affordable housing for seniors and persons with disabilities while helping owners of rental properties fill vacant units and/or offer other affordable rent to current residents. Property owners agree to discount rents by at least 15 percent of the market rent and receive 50% of the discount back in the form of a state tax credit.

Risk Factors in Independent Living Facilities

- On average, low-income elders living in federally assisted housing are over age 80. Most people this age have experienced declining health, widowhood, and retirement. These events often result in the need for supportive services.

- A 1987 Brookings Institute report finds some 850,000 elders, nationally, with severe impairments residing in the community. "Severe impairments" is defined as having limitations in five or six activities of daily living.

- "Naturally occurring retirement communities" (NORCs) are described as the most dominant and overlooked form of senior housing. NORCs presenting the greatest challenge are those with a high rate of older people living alone or with very low incomes, and/or with deteriorating housing and in need of services to remain independent.

Linking Services to Housing for Elders and Persons with Disabilities

- With the increased number of frail elders in congregate housing, the support services needs of these residents has grown and become more complex.

- In some state and federal subsidized housing, housing managers assume no role in assuring that needed services are provided.

- For many elders and persons with disabilities whose needs can be met in independent living facilities, it is more cost effective to provide supportive services than to place the person in a nursing facility.

- Consideration should be given to (a) the residents' need for supportive services, (b) the property management's wish to promote safety and well-being of residents, and (c) state code regarding the types of facilities that are subject to licensure.

Models for Funding Support Services in Assisted Housing

- States fund a statewide service coordinator who directs housing managers to available service resources. No new services or housing are created (Minnesota, Connecticut).

- States provide tax exemption bond financing for construction of congregate housing facilities. Developers are responsible for providing supportive services under loose guidelines, and the states are not involved in service provision or subsidy (Arkansas, Idaho, Illinois, Pennsylvania, North Carolina, Ohio, and Oregon).

- States directly provide and/or subsidize the provision of new supportive services to frail elders in exiting senior housing or newly constructed congregate facilities (Connecticut, Maine, Maryland, Massachusetts, New Jersey, New Hampshire, New York, Vermont, and Oregon).

The following models of joint cooperation are identified:

- The federal government's contributing housing assistance and states' contributing the services to frail elders who occupy the units.

- Federal-state funding of supportive services from savings in Medicaid expenditures that accrue from delayed institutionalization of frail elders.

- Independent of any linkage created through Medicaid savings, federal-state-local funding of services for federal- and state-assisted housing units occupied by frail elders.

Current Virginia Programs Impacting Residents in Independent Living Facilities

- The Northern Virginia Cluster Care and Cost-Sharing Model, the Department of Medical Assistance Services' Personal Care Program Model, the Department of Rehabilitation's Personal Assistant Service Model, Alexandria's Route Companion Services Model, the Comprehensive Supportive Services Model, Southeastern Virginia Areawide Model Program's (SEVAMP) Housing Service Coordination Program, and the League of Older Americans' Melrose Towers Program are some of the models used in Virginia facilities to efficiently and cost-effectively provide support services to facility residents.

The study presents the following recommendations:

- *Recommendation 1*

  The Commonwealth should explore more extensive use of service coordination in housing for elders and persons with disabilities by taking the following actions:

  - Explore public/private partnerships to develop service coordination programs modeled after the Congregate Housing Services program administered by the United States Department of Housing and Urban Development;

- Initiate discussions with the Department of Housing and Urban Development to explore expanded funding under the Congregate Housing Programs to include the cost of service coordinations;

- Provide tax exemption bond financing for construction of congregate housing and allow the cost of service coordination to be included in the operating cost; and

- Explore the feasibility of implementing supportive services coordination in housing developments which target elders and persons with disabilities.

○ *Recommendation 2*

The General Assembly should request that the Joint Commission on Health Care, as part of their current study under House Joint Resolution 639, address whether provisions of Chapter 9 of the Code of Virginia are relevant to independent living facilities and, if so, under what circumstances do those provisions become relevant.

○ *Recommendation 3*

- The Commonwealth should support efforts that link services to senior housing developments, to include Medicaid waivered services;

- Virginia Housing Development Authority should be asked to explore the expansion of its housing training and staff development initiative to include non-VHDA senior housing developments; and

- The Commonwealth should explore how the Office of Volunteerism can work with senior housing management to promote volunteerism, such as the creation and use of resident volunteer cooperatives to compliment the delivery of more formal supportive services.

○ *Recommendation 4*

The Commonwealth should provide guidelines to local service providers to develop a local fee schedule which reflects the uniqueness of the community. Guidelines should address:

- The definition of the target population and how eligibility will be determined;

- What specific supportive services will be delivered;

- A mutually agreed upon scale for all providers of in-home services within the community;

- Minimum income level at which a fee for services will be assessed (i.e., may elect to collect no fee for persons whose income is SSI or less);

- Whether a fee will be based on percent of unit cost or percent of gross income. (A percentage of gross income fee schedule would eliminate the added burden of revising fees based on change of need and authorized hours.);

- What specific deductions from gross income will be made before assessing the fee for services (i.e., the cost of prescription medicines, the cost of rent or a percentage of the cost of rent, Adult Day Care costs, other regularly reoccurring cost of maintaining the person in the community, etc.);

- Under what circumstances will fees be wavered;

- Under what circumstances will services be suspended or terminated for non-payment of fees; and

- To whom shall the consumer pay fees? to the provider? to the provider agency?

○ *Recommendation 5*

To better plan for housing needs of the next 50 years, the Departments of Social Services and for the Aging should proceed with an analysis to identify the areas of the Commonwealth in which the shortage of assisted housing for elders and persons with disabilities is most acute now and project where shortages will be most acute in the next decades.

SERVICE NEEDS OF PERSONS IN CONGREGATE HOUSING

I. INTRODUCTION

A. Study Charge

House Joint Resolution 564 requests the Department of Social Services and the Department for the Aging to study the provision of certain services to low-to-moderate income persons which will allow them to remain in independent living facilities. The resolution requests that the study include:

- the identification and consideration of services which are necessary for older and disabled persons to support their continued residency in the least restrictive settings as their ability to provide for their own needs decreases; and

- a sliding fee schedule through which residents of independent living facilities who are at risk of relocation into more restrictive housing may have access to needed services and thereby avert or delay relocation.

B. Study Objectives

In order to accomplish the intent of the study request, the following objectives were identified:

- to review and analyze demographic trends and philosophy regarding housing alternatives for elders and persons with disabilities which have an impact on independent living facilities and on the demand for independent living housing;

- to review the state-of-the-art programs in state and federally assisted housing in the Commonwealth;

- to review and assess risk factors of elders and persons with disabilities in independent living facilities and to consider methods and cost of reducing risk; and

- to review and evaluate models for funding support services in supportive housing facilities.

C. Approach and Methodology

Responsibility for conducting the study was delegated by the General Assembly through House Joint Resolution 564 to the Department of Social Services and the Department for the Aging. To assist with the study, the departments formed a task force composed of persons with expertise and interest in assisted housing for elders and persons with disabilities. Refer to the Acknowledgements for a complete listing of committee members.

Several approaches and activities were used to respond to study objectives. These included:

- a survey of assisted housing professionals in the Commonwealth who are knowledgeable about pertinent issues;
- a review and analysis of Virginia Housing Development Authority's (VHDA) 1989 study which was conducted in the Commonwealth on related issues;
- a review and analysis of existing funding sources and fee scales; and
- a literature review.

In preparing this report, the committee also drew upon the expertise and experience of committee members.

D. Definitions of Terms

It should be noted that Chapter 9 of the Code of Virginia includes definitions that relate to Adult Care Residences and some of those definitions may be relevant to the topic explored in this study. These regulations include a definition of independent living. It is not the purpose of this study to conduct a comprehensive review of all adult residential facilities in the Commonwealth but rather to focus on federal and state subsidized housing. The following terms are defined for the purpose of this study and are relevant only to the purpose of the study.

(1) **Activities of Daily Living** (as defined by HUD) means eating, dressing, bathing, grooming and household management activities.

(2) **Area Median Income** means the median income established by the U.S. Department of Housing and Urban Development (HUD) for various areas of the state.

(3) **At-Risk Residents** means residents of independent living facilities whose continued unmet needs may result in further deterioration of the resident's well-being.

(4) **Congregate Housing** means a housing facility of independent units specifically designed for elders and persons with disabilities. Some facilities include a central kitchen and supportive environment. This includes independent living facilities.

(5) **Frail elderly** (as defined by HUD) means an elderly person who is unable to perform at least three activities of daily living.

(6) **Low-to-moderate income** means 80% of the median income for the service area as established by the U.S. Department of Housing and Urban Development (also referred to as ***lower income***).

(7) **Necessary Services** means assistance to older residents of independent living facilities which is essential to the older person's continued residency in the facility at an acceptable level of safety.

(8) **Supportive Housing for the Elders and Persons with Disabilities** means housing that is designed (1) to meet the special physical needs of elders and persons with disabilities and (2) to accommodate the provision of supportive services that are expected to be needed, either initially or over the useful life of the housing, by elders and persons with disabilities that the housing is intended to serve.

E. Independent Living Facilities Included in Study

This study addresses the identified need for services to certain residents of congregate housing for elders and persons with disabilities. Persons who reside in congregate housing are considered to be living in their own homes and some, for reasons of frailty or disabilities, want and need in-home services. Such housing consists of independent living units (e.g., individual apartments or efficiencies) in which the residents of the units assume primary responsibility for providing or arranging for the in-home services necessary to maintain their health, well-being and life-style.

Oversight of congregate housing is provided by the funding agency. The purpose of the oversight is to assure compliance with federal and state regulations governing the particular program and to assure appropriate physical and financial management and maintenance of the property so that quality housing is available. This study looks at residents of such housing who wish to remain in the independent living environment but whose ability to provide or arrange for

necessary services is diminished due to the frailty of age, disability, or disease process.

Congregate housing for elders and persons with disabilities is provided under the terms of a lease. There is no contract for services between the property and the elder or the person with disabilities. In such housing, residents who need home delivered services have the responsibility for contracting with the service provider directly. Congregate housing is differentiated from Adult Care Residences (ACR) in which primary responsibility for the provision of necessary services rests with the ACR. ACRs are regulated by the Commonwealth in order to assure an environment which supports a minimum level of safety and well-being of vulnerable adults in out-of-home placements. The Commonwealth achieves its regulatory purposes by regulating the safety and appropriateness of the physical facility, the qualifications and appropriateness of the providers of care, and the adequacy of the program of care.

II. BACKGROUND

A. America: An Aging Society

According to the U.S. Census Bureau, America's 65-plus population grew by 21 percent between 1980 and 1990 to an historical high of nearly 32 million people. An eighth of all Americans are now 65 years old or older, and half of the population is at least 33 years old. Less than a quarter of the nation's population is younger than 16. The proportion of older citizens will continue to grow with the aging of the post-World War II generation (Baby Boomers), who were born between 1946 and 1964.

The oldest-old, those who are 85 and older, are the fastest growing segment of senior citizens. The number of centenarians more than doubled in the last decade. While the under 65 population grew by only eight percent between 1980 and 1990, the 85 plus population skyrocketed at a rate of 35 percent. Although the oldest-old currently constitute only one percent of the total population, they are already having an impact on the nation's families and on its health and social service systems.

According to the Virginia Employment Commission, Division of Economic Information Services, as of July 1, 1994, Virginia's population was 6,551,552. Of that number, 975,604 residents, almost 15 percent of the state's population, were age 60 and older. The over 80 age group represents 17 percent of older Virginians. By the year 2000, it is projected that more than one million residents in the Commonwealth will be 60 and older. The following table provides an overview of the current aging population in Virginia.

CURRENT AGING POPULATION IN VIRGINIA

AGE	NUMBER	PERCENTAGE
60 - 64	254,519	26% of the over 60 population
65- 69	225,702	23% of the over 60 population
70 - 74	184,842	19% of the over 60 population
75 - 79	144,226	15% of the over 60 population
80 - 84	91,676	9% of the over 60 population
85 +	74,639	8% of the over 60 population
TOTAL	975,604	14.8% of Virginia's population

SOURCE: VIRGINIA EMPLOYMENT COMMISSION, ECONOMIC INFORMATION, JULY, 1995

The Virginia Department of Planning and Budget projects that the population in Virginia will have increased nearly 25 percent between 1980 and 2000. During that time, the 60 and older population will increase nearly 46 percent. The 75 and older population is expected to increase more than 91 percent. As a result of this dramatic increase in numbers of older persons, it has become necessary to reassess the way that the Commonwealth houses and provides services to people who are frail or who have disabilities. The following table provides an overview of the projected aging population in Virginia through 2010.

PROJECTED AGING POPULATION IN VIRGINIA

AGE	1990	2000	2010
60 - 64	245,436	263,182	402,569
65 - 69	228,730	222,808	295,520
70 - 74	171,892	197,154	211,493
75 - 79	125,298	162,227	160,362
80 - 84	78,841	103,886	120,481
85+	59,709	88,812	117,556
TOTAL	909,906	1,038,069	1,307,981

SOURCE: VIRGINIA EMPLOYMENT COMMISSION,ECONOMIC INFORMATION, SEPTEMBER, 1995

B. Poverty Among the Elderly: A National Overview

According to the U.S. General Accounting Office (GAO) some 19 percent of the elderly population, over 5.7 million people, were poor or near poor in 1990. More than 12 percent of older men were poor or near poor with almost twice as many older women, 23.4 percent, being so designated. Elderly minorities were two to three times as likely as older non-minorities to be poor or near poor. People who live longer that 75 years are twice as likely as those aged 65-74 to be poor or near poor, 15.1 percent versus 24.9 percent. GAO found that widowhood and retirement are among the critical antecedents of poverty among the elderly. See Appendix B for the poverty status of the 60 and older population in Virginia.

Housing expenses are a major budget item for poor elders as well as persons with disabilities. Whether the low-income person owns or rents his home, half spent more than 45 percent of their income for housing in 1989.

C. Aging In Place and its Impact on the Senior Housing Industry

One of the most persistent dilemmas faced by managers of established independent living facilities or congregate facilities is the *"aging-in-place"* phenomenon. The advantages to frail elders and persons with disabilities of growing old in environments to which they are acclimated is recognized. As residents age, they tend to require more support or services and this places a greater burden upon housing administrators and their staff. For example, many of elders and persons with disabilities living in federally assisted Section 202 low-income housing have lived independently in those facilities for 10 to 20 years. Many, though still capable of independent living, are now becoming more frail and less able to manage all their daily needs.

Not only are current residents experiencing some of the frailties and limitations of advanced age, but the average age of new residents moving into senior housing developments is rising. Aging-in-place requires structural changes within the residence to accommodate a greater level of impairment of persons in advanced old age. These persons may have problems reaching and bending; climbing stairs that do not have rails; bathing in tubs that do not have grabs bars; and functioning in poorly lighted housing. Structural changes that meet the special needs of the impaired elders and persons with disabilities include installation of stair lifts or ramps; modification of appliance and electrical controls for easier manipulation; and the widening of doorways. Adaptation of the residence increases the independence of the older person.

Supportive housing is a growing need as elders age-in-place. Twenty to 30 years ago many non-profit homes for the aged found it necessary to add services as residents aged and eventually some of those facilities made the transition to

nursing homes. Today, more and more structures originally built for seniors capable of fully independent living, or as retirement housing offering limited support, are adding a wider array of care services. Supportive housing comes in a variety of housing options such as retirement communities, congregate housing, adult care residences, and continuing care facilities.

The many implications of adding supportive features to existing housing projects calls for careful consideration. The cost of obtaining qualified employees and the cost of labor, training and benefits will become increasingly expensive. However, the need for supportive housing presents an opportunity in the retirement housing industry to capitalize on the "functional-needs market," which will grow as the baby boomers retire.

III. OVERVIEW OF STATE AND FEDERALLY ASSISTED HOUSING

A. Section 202 Housing

Providing adequate housing for elders and persons with disabilities has been a priority of the federal government. The U.S. Department of Housing and Urban Development (HUD) provides housing for the low-to-moderate income through its Section 202 housing program. This is the only HUD rental housing program designed specifically for elders and persons with disabilities. HUD defines an elderly person as someone who is at least 62 years of age.

Under the Section 202 program, housing is constructed using federal subsidies and is operated by private groups which are required to follow federal guidelines. This results in lower rents than for privately financed buildings. The program was created in 1959 and reenacted with amendments in 1974. In 1974, the program provided for direct 40-year financing to nonprofit sponsors for construction and for low-interest loans, with owners agreeing to limit the units to low-income tenants for 40 years. Today, nationwide, there are about 4,000 Section 202 projects containing 240,000 units (U.S. GAO Testimony, August, 1992). In Virginia, there are fifty-three Section 202 projects, providing approximately 5,392 units of housing for elders and persons with disabilities. A listing of the Virginia's Section 202 properties can be found in Appendix C, along with a listing of Section 236 properties. The Section 236 program is currently inactive and in the past, was used for the construction of housing for elderly persons and persons with disabilities when Section 202 funding was not available. There are 1,751 units of housing in Virginia funded by the Section 236 program.

For years Section 202 projects were developed with project specific, 20 year, 100 percent Section 8 rental assistance contracts. New 202s are now developed as grants. Instead of using Section 8 as a method to provide subsidized rents to residents, Project Rental Assistance Contracts (PRACs) are being used to provide

rental assistance. For more information on the Section 8 rental assistance programs see Appendix D.

The plight of older persons in need of housing assistance became worse during the 1980s. The number of older households with annual incomes below $5,000 and the number of older persons who were poor increased (Redfoot and Gaberlavage, 1991). At the same time the number of unsubsidized low-rent units in the private sector declined, a decline offset partially by a slow growth in subsidized low-rent units (Lazare, Leonard, Dolbeare, and Zigas, 1991). Federal support for construction programs that had served elders and persons with disabilities was diminished: funding for Section 202 housing was diminished by half; major cuts occurred in the Section 515 rural rental housing program; and, new public and Section 8 housing certificates virtually ceased (U. S. House of Representatives 1989). These housing programs have played an important role in meeting the needs of frail low-income elders and persons with disabilities and will be especially critical as the number of frail older persons increases over the next several decades (Pynoos, 1992; Struyk, et al., 1989).

It is estimated that there are approximately a quarter of a million people nationwide now on waiting list for Section 202 housing. According to a 1988 study of 202 housing, there were approximately eight applicants over age 62 waiting for every unit that becomes vacant annually. Ten percent of all applicants had been waiting for more than four years. Vacancy rates are extremely low (1.4%). In Virginia, most localities have two year waiting lists for 202 housing. Waiting lists do not represent those individuals who have been discouraged by long waiting lists and therefore are not submitting their names for consideration.

A 1993 California study documented long waiting list and unmet need for supportive housing. Recommendations from that study are relevant to the housing needs of elders and persons with disabilities in Virginia. Those recommendations included the following:

(1) Compile existing waiting list data to identify areas with shortages of affordable housing. These data should then be used to target additional housing resources to regions that are found to have the greatest need;

(2) Expand programs (such as the Section 8 rental assistance certificate program) where excessive waiting lists of qualified applicants exists, and create a stable program of income support to cover the cost of housing low-income persons who cannot obtain subsidized housing;

(3) Augment programs that provide new and rehabilitated housing;

(4) Expand government-assisted housing programs to better serve older applicants who need supportive physical settings linked with services;

(5) Provide individuals with information on programs designed to meet their immediate housing, income, and service needs (for example, food stamps, home-based services, Supplemental Security Income, etc.) at the time they apply for housing assistance;

(6) Create a new program of housing counseling for older persons;

(7) Consider using functional limitations and/or health-related problems as criteria for assigning priorities for admission to housing to elders and persons with disabilities.; and

(8) Create a clearinghouse for information and improve the application process for housing assistance.

B. Congregate Housing Services Programs (CHSP)

The need for supportive housing is met for elders and persons with disabilities living in housing sites that offer HUD-funded Congregate Housing Services Programs (CHSP). This program provides supportive services for residents but does not provide nursing care. Nationally, there are 59 grantees in CHSP, 29 of which are Section 202 developments, and 30 conventional public housing developments (National Institute on Housing, 1991). In 1991, the program served approximately 1500 elders, 350 non-elderly persons with disabilities, and 150 persons who were temporarily disabled. For projects serving elderly persons, HUD provided 67 percent of the costs of the program, participants paid 14 percent in fees, and 19 percent came from third-party and in-kind sources. Currently there are no CHSPs operating in Virginia. CHSPs are not subsidized, and they usually operate at fair market rental rates. Therefore, they have no impact on older low-to-moderate income renters. For more information on CHSPs, refer to Appendix E.

C. HUD'S Supportive Housing for the Elderly and Persons with Disabilities Initiative

The Housing and Community Development Act of 1974 required HUD to seek to assure that Section 202 projects provide a range of supportive services, such as health, welfare, and transportation, and encourage residents to use them. A 1988 survey of Section 202 projects found a growing gap between the demand and supply of Section 202 units for elders and persons with disabilities. The survey also found that as projects have aged, the average resident has become increasingly older, more frail, and in greater need of supportive services. At the same time there has been a shift away from supportive design features over the history of the 202 program.

In view of these findings, Congress recognized in the Cranston-Gonzalez National Affordable Housing Act (NAHA) of 1990 that there is a need to expand the supply of supportive housing for elders and persons with disabilities.

The NAHA was the first comprehensive housing act since 1974. The act established and redesigned an array of supportive housing programs for elders, persons with disabilities, and the homeless. Supportive housing programs are linked to efforts to maintain or restore independent living arrangements and to increase earning potential. The act continues housing programs for rural areas, and calls for more assistance in remote and under-served communities. NAHA places housing back on the national agenda after a long period of declining support.

The *Supportive Housing for Elders and Persons with Disabilities Program* funded under *Section 801 of NAHA* requires HUD to ensure that Section 202 projects approved after September 30, 1991, provide a range of services tailored to the needs of residents on an ongoing basis, and that owners assess, coordinate, and finance a supportive services program. The selection of 202 projects after this date is to be based (among other criteria) on the ability to meet the service needs of elders and persons with disabilities.

Section 802 of NAHA authorizes activities to enhance the provision of a supportive housing environment in existing 202 projects. These projects can apply for funds to retrofit units and buildings in order to meet the special physical needs of frail elders and persons with disabilities and to accommodate supportive services that enhance independence (e.g., installing hand rails or non-slip surfaces, or adding space for eye examinations).

Supportive Services means services determined by HUD to address the special needs of frail elders. Examples include case management, personal care and grooming, transportation and meals, housekeeping, laundry, counseling, non-medical supervision, wellness programs, preventive health screening, and monitoring of medication. An applicant (e.g., 202 sponsor) may seek HUD approval to provide other services essential for achieving and maintaining independent living. Services may be provided directly by the public housing authority agency, 202 sponsor, or through a third-party provider. To be eligible for the program, persons must be 62 or older and income eligible for the Section 8 program. Eligible persons must need assistance in at least three ADLs, i.e., eating, bathing, grooming, dressing and home management activities. In Virginia, there are 53 Section 202 projects. Of those, four provide service coordination: Beth Sholom Woods in Richmond; Lafayette House in Petersburg; William H. Puller Plaza in Suffolk; and Covenant Place in Smithfield.

Evidence suggests that there is insufficient funding to meet the growing supportive services needs of residents in existing Section 202 projects, and to meet the adaptive modification requirements that are necessary to retrofit 202 projects. This suggests the

need for a system to identify the areas of greatest need so that limited funds can be targeted.

HUD recognizes the "aging-in-place" phenomenon that is taking place among residents in HUD housing. HUD also notes that housing project managers do not have the training and skills necessary to deal with the need for supportive services and generally do not have time to perform both social services and housing functions. HUD defines a service coordinator as a staff person who works with tenants in need of support, refers them for assessment, links them with service providers in the community and monitors provision of services.

Aging-in-place has an impact on 202 housing as residents experience increasing need for help with basic living activities. Among the 202 facilities occupied before 1983, the average resident's age rose from 72 years in 1983 to 75.2 years in 1988. Those facilities occupied between 1959, when 202 housing was established, and 1974 houses residents whose average age in 1988 was 77 years. Thirty-five percent of the residents in the oldest facilities are over the age of 80 years and nearly 25% of new applicants to older projects are also over the age of 80.

Many Section 202 programs have not yet established ways to provide to residents assistance with home maintenance and personal care. Only 6.5 percent of all Section 202 facilities provide assisted independent living with the availability of at least five hot meals per week and on-site housekeeping services.

In an effort to identify the service needs of residents in federally assisted housing, a survey of the three HUD properties currently providing service coordination was conducted. The survey was completed by Beth Sholom in Richmond which has 111 units, Lafayette House in Petersburg which has 100 units and William Plummer Plaza in Suffolk, which has 49 units. The survey solicited information pertaining to the service needs of residents and the most frequently requested services. Responses are as follows:

What supportive services are most frequently used by residents?

Lafayette House	William Plummer Plaza	Beth Sholom
Transportation	Personal Care	Meals
Health Related Services	Housekeeping	Transportation
Meals on Wheels		Housekeeping
Housekeeping assistance is frequently needed but difficult to obtain		Case Management
		Home Health

In Virginia, many residents of senior housing facilities benefit from personal care services provided by the Department of Medical Assistance Services' Home and Community-Based Care Program. However, these services are limited to individuals who are Medicaid eligible and meet the Virginia Medicaid criteria for nursing home care. This leaves a considerable gap in services for elders and persons with disabilities who need some assistance with in-home care. In-home services are core services provided by all 124 local departments of social services and all 25 Area Agencies on Aging. Service provision is limited due to budget constraints. For complete results of the survey of HUD properties providing service coordination see Appendix F.

IV. SUPPORTIVE SERVICES IN VIRGINIA'S SENIOR HOUSING

A. Identification of Needed Services

HJR 564 asked that the study consider and identify the services which are necessary to maintain elders and persons with disabilities in the least restrictive home setting. Frailty and chronic disability usually means greater reliance on others to provide help with daily living activities. The following list itemizes those services which are generally acknowledged by professionals in aging and disabilities to assist elders and persons with disabilities to carry out day-to-day living tasks. These services commonly include:

- assistance in accessing services
- food preparation (the cornerstone to creating any living environment for the old and increasingly frail and dependent is the assurance of three nutritious meals a day, every day)
- assistance with laundry
- assistance with personal care (e.g., grooming, hygiene)
- home health services (nurse monitoring, medication administration)
- assistance with transportation (including escort services)
- home repairs or maintenance
- shopping assistance
- medication reminders
- emergency call system
- legal services
- mental health services
- money management and bill paying
- telephone reassurance
- recreation and socialization services

B. The Robert Wood Johnson Foundation Supportive Services in Senior Housing Initiative in Virginia

In November, 1988, the Virginia Housing Development Authority (VHDA) was selected by the Robert Wood Johnson (RWJ) Foundation as one of ten state housing finance agencies to participate in the *Supportive Services Program in Senior Housing*. Under this program, VHDA was awarded funding over a three-year period to assist in the development of innovative, affordable, and efficient means of delivering supportive services to older people living in VHDA-financed subsidized housing developments for elders and persons with disabilities.

This national initiative was a joint undertaking of the Robert Wood Johnson Foundation, the nation's largest health care philanthropy, and the National Council of State Housing Agencies. The purpose of the initiative was to meet the needs of an increasingly aging tenant population. The foundation and the council provided technical assistance for the program to VHDA, which in turn, provided support and assistance through its Housing Management Division to owners and managers of housing developments throughout Virginia. Staff from Area Agencies on Aging assisted by sharing their knowledge about the elderly and the community resources that serve them.

Of the over 900,000 older Virginians, 17,000 to 18,000 live in senior housing developments that receive public assistance. As these developments have aged, so have the residents. There is a need for more supportive services in order for the residents to remain independent. The VHDA Supportive Services Program is designed to support the continued independence of residents by supplementing the existing services of informal care provided by friends and relatives with services currently unavailable or inadequate.

The specific services to be provided depends on the desires and needs of the residents, as well as cost. Examples of services which may be offered are: housekeeping; transportation; meals; shopping assistance; companion services; socialization/recreational activities; and financial management. The cost of these services are underwritten by a combination of fees paid by residents, contributions or subsidies provided by the housing development and community resources. Appendix G provides a program summary of the VHDA Supportive Services Program in Senior Housing funded by the RWJ initiative.

As Phase I of the program culminated, efforts were made to determine the characteristics of residents participating in the program and to gain insight into residents' preferences for services. A survey of the participating housing developments was conducted which resulted in the following findings related to residents' preferences for services.

Services Tenants "Very Likely" to Use	Survey Results
Transportation	30.3%
Heavy Housekeeping	27.7%
Finding Assistance	26.6%
Shopping	25.1%
Light Housekeeping	16.4%
Meal Preparation	10.0%
Personal Care	9.0%

SOURCE: Supportive Services Program in Senior Housing, VHDA Survey, May, 1989.

VHDA continued the supportive services initiative after the RWJ funding ended. It has extended the program to 17 of its 53 senior housing properties. For the purpose of this legislative study, efforts were made to conduct an informal survey of these properties to solicit input regarding the supportive services utilized and/or needed by older tenants. Responses were received from 24 properties (approximately 50 percent) and, although the results are anecdotal, service needs of tenants are apparent. The result of that survey found the types of services regularly used by residents to mirror the 1989 results. Services usage by ranking are as follows:

1. Housekeeping assistance
2. Congregate Meals/Home Delivered Meals
3. Transportation
4. Personal/Companion Services
5. Home Health Services
6. Shopping Assistance

See Appendix H for results of the June 1995, survey of VHDA senior housing developments. A successful Supportive Services Program depends upon acceptance and support from the tenant population, as well as from owners and managers of housing facilities. Therefore, an important element of the program is education, training, and marketing. Through a continuing educational program, VHDA hopes to sensitize owners and managers to "aging-in-place" and the importance of supportive services to resident well-being.

V. OTHER STATE SPONSORED SENIOR HOUSING INITIATIVES

The Virginia Housing Partnership Fund is state sponsored. Decent, safe and affordable housing is a basic need for all Virginians. Many people of modest means experience severe problems finding and maintaining adequate, affordable housing. The 1987 annual report of the Virginia Housing Study Commission documented a housing crisis and in response, the Governor and the 1988 General Assembly established the Virginia Housing Partnership Fund (VHPF). The purpose of the VHPF is to support and encourage improvement of housing resources and opportunities available to lower-income Virginians. The VHPF is administered by the Virginia Department of Housing and Community Development (DHCD) with the Virginia Housing Development Authority providing assistance with underwriting, accounting services and project compliance monitoring. The funds supports housing developments for special populations, such as elderly persons and persons with disabilities. Other state-funded senior housing initiatives include the Congregate Housing Program sponsored by DHCD and the following VHDA programs: the Low-Income Tax Credit Program, Tax Exemption Bond Financing, and the Rent Reduction State Tax Credit Program. Refer to Appendix I for more information about these programs.

VI. RISK FACTORS IN INDEPENDENT LIVING FACILITIES

A. Indicators of Risk

Three common events in the lives of elders often result in need for supportive services. Those events are: declining health, widowhood, and retirement. People over 80 have usually experienced all three of these events. They suffer most from the lack of housing and services coordination (MacAdam, 1995). On average, low-income elderly living in federally assisted housing are over age 80. They often find it difficult to access services they need and the physical environment of their apartment is not supportive of their needs (Pynoos and Lanspery, 1993). The growth in the elderly population has implications with respect to their need for housing and support services since the prevalence of chronic diseases increase with age. Chronic disease, including cognitive deficits and impairing illnesses, are associated with an increase in limitations on activities of daily living (ADL, e.g., bathing and dressing), or limitations on instrumental activities of daily living (IADL, e.g., shopping, and preparing meals). Individuals who experience ADL and IADL limitations may require more supportive environments in order to maintain semi-independence in the community. According to the 1987 National Medical Expenditure Survey, about 11 percent of persons aged 65 to 74 living in the community have some limitation for which they require assistance. This figure climbs to 57 percent among those 85 and older.

B. Risk for Institutionalized and Community Based Elders and Persons with Disabilities

For every person aged 65 and older residing in a nursing facility, there are nearly two others living in the community who require some form of long-term support. According to the 1987 Brookings Institute report, there were approximately 4.9 million elderly persons residing in the community in 1985 (18 percent of the population over age 65) who had ADL limitations. About two-thirds of these elderly persons had only moderate impairments; that is, fewer than three ADL limitations. However, some 850,000 elderly persons were severely impaired, which is defined as having a limitation in five or six ADLs. The Department for the Aging federal funding is based on two percent of it's older population having severe impairments. In Virginia, there are 721,085 older persons age 65 and older. With two percent of elders in that age group having severe impairments, that approximates to 144,217 older Virginians living in the community with severe ADL limitations.

C. Naturally Occurring Retirement Communities (NORCs)

The phrase "naturally occurring retirement community" (NORC) was coined in the 1980s by researchers at the University of Wisconsin-Madison and has evolved to mean any building or neighborhood where a disproportionate number of the residents are over 60. According to a 1992 American Association of Retired Persons (AARP) survey, 27 percent of older people live in a "building or neighborhood where more than 50 percent of the residents are over 60."
The report describes NORCs as the most dominant and overlooked form of senior housing. A national study conducted at the Heller School's Policy Center on Aging (Brandeis University) supports this conclusion.

NORCs vary according to size of the population, the demographic characteristics of the residents, the way the NORC was created (whether older people moved in, younger people moved out, or both), and the characteristics of ownership. A "closed" NORC has a single owner or management entity (e.g., condominium complex, an apartment building, a mobile home park) while an "open" NORC includes multiple owners or management entities (e.g., a neighborhood of one- or two-family homes).

The NORCs presenting the greatest challenge are those with a high rate of older people living alone or with very low incomes, and/or with deteriorating housing. NORCs also present an interesting opportunity for linking housing and services. Programs have been established in some parts of the country which link NORCs and services. The Brandeis study found programs only in closed NORCs. Those programs look much like programs linking planned senior housing and services. A common example is an apartment building in which the owner, manager, or

cooperative association contracts with a social services agency to provide some services (usually social work, case management, or information and referral). Most programs have developed as a reaction to numbers of crisis calls from the same location or a building manager requests help with dealing with problems of aging-in-place. Some organizations are exploring models that seeks to build a sense of community, including working with residents to develop social and educational programs, and develops new services (on a fee-for-services basis) according to consumer interest.

Over time, NORCs programs may help to stabilize neighborhoods, improve property values, reduce older residents' isolation, and postpone institutionalization. Providing services to residents of NORCs may improve the way an agency does business (i.e., locate certain services in the NORC area, target services more effectively to a dense population of older people, cluster services and serve more people for the same amount of money, etc.). All older people in the area could benefit from this service improvement.

VII. LINKING SERVICES TO HOUSING FOR ELDERS AND PERSONS WITH DISABILITIES

A. Benefits Attributed to Supportive Service Coordination Based on a Review of the Robert Wood Johnson Foundation National Initiative

The 1988 Supportive Services Program in Senior Housing (SSPSH), as part of the national initiative of The Robert Wood Johnson Foundation, funded ten state housing finance agencies (HFA) to integrate housing and services programs for elders and persons with disabilities in over 240 federally assisted housing developments. This initiative provided valuable information concerning organizing and financing services in senior housing through traditional and nontraditional funding sources. The SSPSH has shown that HFAs, development owners, and housing managers can and should be added to the potential service resources available to older people. Creating supportive services programs present special challenges. Three critical policy questions are:

- **Who should pay for supportive services to residents?** Local agencies, the usual providers, charge service costs primarily to the Older American Act, Medicaid, (via 2176 waivers), the Social Services Block Grant and special state and local initiatives. In the federal CHSP and some state programs, these sources are coordinated to an extent; usually they remain separate.

- **Who should be able to receive services?** Historically, subsidized or free services have been targeted to those meeting strict eligibility criteria based on income, need for assistance with activities of daily living or both.

Income eligibility limits tend to be low, and "need" is usually defined by a professional assessment.

- **What role should residents have in defining the type of service offered?** Services are typically determined by program rules that may be inflexible and onerous.

The SSPSH addressed each of these policy questions as follows:

- Residents often paid a portion -- in some cases, all -- of the cost of the service, and housing sponsors made a significant financial investment;

- Most of the services developed by the SSPSH were available to all residents, not just those who were poor and/or frail; and

- Residents had a voice in what services were to be developed through the program. They participated in market surveys, focus groups, and resident associations as well as "voting with their wallets."

Housing finance agencies under the SSPSH established housing and service programs for older persons in over 240 federally assisted housing developments through August 1991. This means that about 25,000 apartments (30,000 individuals) stood to benefit from the availability of SSPSH-initiated services. Over 170 developments offered service coordination; 80 offered housekeeping and heavy chore service; 50 offered transportation or shopping assistance or both; 30 offered meals. Many less formal arrangements also existed -- for example, housing managers contracted with service workers who dealt directly with consumers. In addition, most housing developments offered on-site services such as routine health care and screening, assistance with programs such as Supplemental Security Income (SSI), Medicaid, Medicare, and food stamps, banking, hair care, and educational and recreational activities. Developments paid at least $2.5 million and residents over $300,000 toward these services.

Benefits associated with the implementation of supportive service coordination were identified as follows:

- Housing development owners were convinced that promoting resident independence, supporting managers, reducing manager and resident turnover, improving building maintenance, and improving the developments' marketability represented a good return on investment. Market survey results demonstrated the need for services and the potential for resident payments.

- Housing managers recognized the benefit of enhancing their ability to keep residents independent and reducing pressure on themselves and their staff to solve social problems.

- The initiative found that residents are interested in purchasing services that enable them to stay independent, especially when using supportive services is seen not as an admission of frailty but as an exercise of independence.

The SSPSH initiative operated on the assumption that, in order to ensure that services were both appropriate and used, residents must play a primary role in service planning and service delivery. The advantage of consumer choice include:

- Promoting resident autonomy: Residents, owners, managers, and families shared the goal of fostering residents' independence and helping them remain in their apartments. When consumers make the choices, instead of having services prescribed for them, they feel more in control and are less likely to fear that they will be stigmatized for being weak or "taking charity," or that they will be evicted. Managers and residents in numerous developments reported stronger resident associations and other indications of healthier resident communities as a result of the SSPSH.

- Willingness to pay: Residents appeared more willing to help pay for services they wanted. For example, in some states residents paid for SSPSH services because of superior quality or greater flexibility, even though they were eligible for similar, less expensive non-SSPSH services.

- Quality assurance: The "power of the pocketbook" helped ensure that services not desired or of poor quality had a short tenure.

- Improved staff-resident relationship: A consumer-oriented program helped to remind staff to treat residents as partners. Many managers reported that they were surprised at how much residents could contribute to starting and maintaining supportive services programs.

- Impact on service providers: With services based on consumer choice, service provider agencies were more likely to "cluster" services. One agency saved enough money by clustering homemakers services to serve additional residents. Another agency that won a contract for service coordination followed up with an attractive proposal for minibus services. The resulting arrangement represented a better use of the minibus and affordable transportation for residents.

- Reducing owner liability: Owners who become involved in offering services reduce their liability by leaving service choices to consumers. Prior to the SSPSH, most owners and managers assumed that involvement in services would increase their liability and avoided any mention of services in management policy. Yet as residents aged in place, managers were often involved de facto in services simply by responding to residents' requests. The lack of policies and guidelines tended to increase liability as well as inhibit resident-management communication.

The guiding principles for the ten HFAs were constant -- consumer choice, expanded service coordination, and housing sponsor involvement. Successful program models must be flexible and responsive to changes in consumer preferences as well as to other factors that may influence program implementation. These factors include: What services are available; what are the eligibility requirements of existing service programs; what is the demographic profile of elderly and persons with disabilities living in the state's senior housing; what are the characteristics of developments potentially affected by the program (e.g., location, size, type); and what are the resources of the housing sponsors? For purpose of description, the following four program models capture most of the characteristics of the HFAs' diverse approaches.

- On-site service coordination: This was the most common among developments participating in the SSPSH. The developments hired or contracted with a full- or part-time supportive services coordinator.

- Regional service coordination: Regional coordinators were based with the HFA: within a single management company and responsive to their portfolio; or with multiple management companies or developments in a geographic region. This model may help to overcome geographic obstacles, bring service coordination to developments with too few resources to hire an on-site coordinator, and develop more affordable services because costs are spread further.

- HFA staff and development managers as service coordinator: In this model, responsibility for initiating and supporting the developments' service programs was more centralized. In this model, HFA staff members set up the services and development managers, often working additional hours, oversee day-to-day operations such as marketing, sign-up, price-setting, payments, and quality assurance. Managers must be willing and able to assimilate training about services and handle new responsibilities.

- Resident initiative: In this model, which is nearly always combined with another model, residents influence directly not only the services offered but also the choice of provider.

  Consumer-oriented service coordinators help residents to obtain the services they want rather than tell them what services they should or must have. They:

  - arrange affordable or free services based on economies of scale; on what residents have to offer as consumers; on the development's attractiveness as a site for seminars, health screening, recreational programs; and on helping residents obtain services for which they are eligible;

  - oversee on-site services (e.g., housekeeping, transportation);

  - help residents to obtain equipment such as grab bars and advocate for modifications such as lever handles, user-friendly locks, and lower peepholes;

  - increase residents' disposable income, through SSI, Medicaid, food stamps, and other programs or discovering that residents have allowable deductions to income (which lowers their rent) -- thus making money available to purchase services; and

  - work closely with resident groups to obtain their input about services and to help strengthen the resident community, responding to residents' desires for informal support, meaningful participation, and better problem resolution.

B. Government's Role/Interest in Service Linkage

Federal and state governments have become more aware of the aging population in independent living facilities and the increasing inability of many elders and persons with disabilities to continue to live independently. The provision of housing alone becomes inadequate for elderly and persons with disabilities who have become increasingly more frail or impaired and as a result require assistance with basic activities of daily living. Historically there has been no continuum of care in independent living facilities that help the frail elderly and persons with disabilities move from minimal supportive services to more intensive care as is found in nursing facilities. The sharp differences in levels of care offered results in some elders and persons with disabilities continuing to live in independent apartments well beyond their ability to care for themselves and their apartments while others enter nursing facilities prematurely without real need for the

intensive medical and supervisory care that is provided there (Sturyk, Page, Newman, et al., 1989).

Government has an interest in actively coordinating and providing a continuum of care and service for frail elders and persons with disabilities in independent living facilities, for three reasons:

- The support service needs of frail elders and persons with disabilities have gone well beyond the resources and experience that housing managers have for meeting them.

- To the extent that some elders and persons with disabilities are placed in nursing homes without really needing the full, costly level of support provided there, the public dollar could be more effectively spent in providing only the necessary level of assistance in a noninstitutional setting.

- Aside from administrative and efficiency rationales for expanding home- and community-based services, government may believe that it has a desire and/or responsibility to help make up the existing supportive service deficit for its low-income, frail elders and persons with disabilities.

C. The Changing Housing Population and Service Coordination/Linkage

The need for service delivery to residents of assisted housing and the coordination of those services has long been recognized by property managers and aging professionals. The question raised by service delivery considerations is whether this constitutes a change in the mission of assisted housing from the provision of safe and decent housing to an expanded role to include the provision of care for personal well-being and safety.

The basic function of housing management changes when, confronted with housing residents who need considerable assistance in planning for and securing the services they need, management employs staff to assist with these tasks. Once the resident of housing is having plans made for him/her rather than being given information needed to plan for self, the question is raised as to whether the broader community has an interest in assuring that safeguards are in place to protect the safety and well-being of the resident.

Independent housing for elders and persons with disabilities, and adult care facilities, which also provides housing for elders and persons with disabilities, differ in their level of responsibility for service provision to their respective residents. When additional responsibility in this area is assumed by independent

housing facilities, the distinction between the two types of housing facilities is less apparent.

VIII. MODELS FOR FUNDING SUPPORT SERVICES IN INDEPENDENT LIVING FACILITIES

A. Three Models Utilized in Other States

Nationally, it is estimated that roughly 105,000 residents, about seven percent, in independent living facilities over the age of 65 are in need of assistance with at least one activity of daily living (ADL). This number is larger than the number who will actually require institutionalization within the next two years, but it is less than the one-third of those residents who have some degree of frailty. Still, the 105,000 figure is an identifiable group that can be considered *at risk of institutionalization* and on whom a service program could expect to target its services. This population needing services is expected to grow with the increase in the number of elders over age 75. The need would likely increase further if more support services were found, attracting frail persons to housing projects offering them. Although many states recognize the need for the coordination of services for residents of congregate housing for elders and persons with disabilities, only a few have responded. Three models or levels of involvement can be identified:

- States fund a statewide service coordinator who directs housing managers to available services resources -- no new services or housing are created (Minnesota and Connecticut);

- States provide tax exemption bond financing for construction of congregate housing facilities. Developers are responsible for providing supportive services under loose guidelines, and the states are not involved in service provision or subsidy (Arkansas, Idaho, Illinois, Pennsylvania, North Carolina, Ohio, Oregon and Virginia); and

- States directly provide and/or subsidize the provision of new supportive services to frail elderly in existing senior housing or newly constructed congregate facilities (Connecticut, Maine, Maryland, Massachusetts, New Jersey, New Hampshire, New York, Vermont, and Oregon).

Experts in the field recommend the third model as the most appropriate for residents of existing assisted rental housing which houses people who require more support services than are currently available and who would not be able to pay for them without government assistance.

State and federal governments have an interest in providing for frail elders and persons with disabilities living in assisted housing. Both fund congregate housing facilities for elders and persons with disabilities. Traditionally, both have shared the responsibility for providing health and welfare services, and both would benefit from savings accrued from reduced institutional costs through the provision of supportive services. Therefore, models of joint federal-state funding and cooperation are appropriate. Three models of joint cooperation have been suggested:

- the federal government's contributing certain forms of housing assistance and states' contributing the services to frail elders and persons with disabilities occupying these units;

- federal-state funding of supportive services from the savings in Medicaid expenditures that may accrue from delayed institutionalization of the frail elders and persons with disabilities (there is considerable debate about the existence and magnitude of these savings); and

- independent of a possible linkage created through Medicaid savings, federal-state funding of services for federal- and stated-assisted housing units occupied by frail elders and persons with disabilities persons.

In coming years, experts suggest the third option to be the most viable, in large part because of the lack of essential information about the others, such as the likely savings to Medicaid associated with more efficient congregate housing programs and the realistic range of parameters for the first model (i.e., federal housing/state services). State programs which evolve under option three would share certain standard elements, such as targeting and tailoring requirements. Federal agencies would play a significant role in designing such programs. There is also room for, and a need for, state participation in the design and implementation of services programs.

B. Block Grants

Social Services Block Grants are authorized under Title XX of the Social Security Act, as amended in 1981, for the purposes of consolidating federal assistance to states for social services into a single grant. States provide direct services to achieve one or more of five goals. The five goals are related to promoting economic self-support and self-sufficiency, preventing and responding to abuse, neglect, and exploitation of children and adults, preventing inappropriate institutionalization, and facilitating admissions for institutional care when appropriate.

C. Older Americans Act

The Older Americans Act (OAA), was enacted in 1965 to promote the well-being of older persons, distributes federal funds to states which, in turn, provide a broad range of supportive services. All persons age 60 and older are eligible to receive services, but states are required to target assistance to persons with "greatest social and economic need."

Federal funds are distributed to the states using a formula based on the state's share of the U.S. population age 60 and over. The Virginia General Assembly also provides General Funds to targeted aging services.

D. The Department of Medical Assistance Services' Personal Care Program Model

Under the Department of Medical Assistance Services' Personal Care Program, eligible persons may receive personal care and/or respite care services. Personal care services provide eligible individuals with personal care aides who perform basic health-related services. Respite care is designed to provide a temporary relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or disability. The focus of this program is on the caregiver's need for temporary relief from caregiving duties.

E. Department of Rehabilitative Services Personal Assistance Services Program

Eligibility for the Personal Assistance Services Program includes: a severe physical disability and assets under $10,000. There are no age restrictions and fees are determined using a sliding scale. The recipient of this service recruits, schedules, trains, supervises, and terminates the services of his/her assistant. Priority for the service is given to people who are in or about to enter a nursing home; people who are at risk of losing employment; people in situations of extreme family stress; and people who are experiencing acute medical problems, or risk of the same, due to the need for non-medical personal assistance.

IX. CURRENT VIRGINIA PROGRAMS IMPACTING RESIDENTS IN INDEPENDENT LIVING FACILITIES

A. The Cluster Care and Cost Sharing Model

In the continuum of long term care for elders in Northern Virginia, there is a lack of sufficient alternatives to nursing home care which can adequately meet the needs for supportive services to the at-risk population of frail elders. The model programs presented in this section highlight the possibilities of providing supportive services to this population. Public agencies providing services found

that some financing methods such as auxiliary grants did not work in the Northern Virginia economy. To solve this problem and meet the need for supportive services, each of the Northern Virginia models presented developed innovative financing packages which combined several sources of funding to make the program work. Therefore, the agencies were able to provide gap filling supportive services to the frail, at-risk population who happen to live in a high cost of living economy.

The Fairfax Area Agency on Aging and Department of Family Services have developed a public-private partnership in its shared aide (cluster care) and cost sharing model called the *Home Care Aide Cost Sharing Program*. The program serves public and private low to moderate income senior residences. Services may be provided to younger disabled residents who are eligible for the program and live in the program sites. In program year 1996, the goal is to serve 104 residents, providing 6,633 hours of service.

Funding for the program is a mix of Fairfax County General Funds, a grant from the Commonwealth of Virginia through the Virginia Department for the Aging, participant cost sharing and public-private partnerships. In the public-private partnership, the private sector residence must match a minimum of a half-time homemaker position to the grant funded full-time position at the site.

The goals of the Fairfax Cost-Sharing Model include the following:

- To help secure and maintain maximum independence and dignity in a home environment with appropriate supportive services and to provide a continuum of care to the vulnerable elders and persons with disabilities;

- To meet the service needs of a maximum number of frail elders and persons with disabilities in the most cost effective manner;

- To provide quality services utilizing a multidisciplinary team approach; and

- To promote private/public partnerships as important linkages to community based services which enable frail elders and persons with disabilities to remain at home.

The early intervention-prevention model involves the teaming of a homemaker, with in-kind services of a social worker, registered nurse and on-site resident manager. Program participants receive the services of the case management team and agree to task-oriented methods of service with a limit of six hours of service delivery per week. The participants must share the cost of services based on the Virginia Health Department fee scale. The maximum level of the fee payment

scale is below the cost of private market services. The fee for a participant may be adjusted for ongoing medical expenses.

Each home care aide (homemaker) is assigned to an independent living facility to provide assistance to multiple residents according to their assessed needs. The aide moves from apartment to apartment in his/her assigned route, staying only long enough to complete the specific tasks for each individual. This approach in providing in-home care to elders and persons with disabilities differs from the traditional approach in two ways:

- the aide is assigned to a supportive housing complex where numerous individuals in need of assistance can be served in a shortened time frame because travel time is eliminated; and

- the aide has no responsibility to work for an individual for a set number of hours, but spends only the time necessary to complete specific tasks.

Cost savings accrue from the elimination of travel for the aide, the serving of multiple residents in a shorter time frame than traditional home care approaches allow, and from the potential for performing certain tasks for several residents at the same time (e.g., laundry and shopping). The advantage to residents may be the availability of a person to stop by to accomplish specific tasks that take little time (e.g., to remind a person to take medication or attend to personal grooming) but would be cost prohibitive under the traditional approach of paying for a larger block of service time. Residents who participate in the program usually received fewer hours of service but continue to have identified needs met.

The case management teaming enables closer monitoring of the status of residents as they continue to age-in-place, therefore changes in the status of residents can be detected earlier and further needs discussed in the team environment. An added advantage to this model is the increased building security that accompanies having a minimal number of visitors in the building. Service providers become known to staff and residents and confidence in building security increases.

B. Alexandria's Route Companion Services Model

In the Alexandria Department of Social Services' Route Companion Services Model, task-specific companion services are provided by a team of aides to a group of seniors and disabled persons who live in close proximity. With this approach a team of four to six aides are able to serve 30 or more eligible citizens living in a senior high-rise apartment.

The traditional approach to companion services delivery required a companion to work for two to four hours for a particular frail elder or person with disabilities

several days each week. With the route system the team is assigned to complete identified tasks to meet the needs of all of the recipients. Any team member or a combination of members can do the work required. The tasks to be completed are described in the individual case plan which is shared with the team.

The route system is more economical as the aides may move on to the next address when finished, and they are not required to remain for a specific time period after completing their tasks. Because of the close proximity of seniors and the freedom to focus upon the well-being of the service recipient, the aids can easily drop in to "check" on them.

By utilizing companion aide teams to provide services to groups, both the recipients and the companion aides benefit. On the one hand the needs of the elders and persons with disabilities are consistently met because of the teams' daily availability and the reduced absenteeism of an assigned companion caused by turnover, illness or vacations. The stress of the assignment is reduced as companions can invite assistance of a team member when necessary. They know the job will still be done even if one team member must be absent for some reason. Requests for groceries or pharmacy from several households can be handled by a single trip.

The route-system services have the same income eligibility criteria as the traditional service. It is best utilized when recipients have residency in a congregate facility. Through individual case planning, the social worker may determine that certain individuals in congregate facilities are better served using the traditional approach to companion services. This occurs when more intensive services are required to reduce isolation, or when the assignment is complex because of language barriers, mental health or family issues.

For fiscal year 1995, an average of 62.5 adults were served each month via the route system. The average cost per resident, per month was $169.00. This is considerably less than the cost of traditional companion services which was $304.00 per month.

C. The Comprehensive Supportive Service Model

Arlington County funds a program (Services for Continuing Independence) that provides one social worker, an evening meal five days per week and homemaker/personal care services in a HUD funded Section 202 building with 300 units. This program has been in operation since 1986 and is open to all residents regardless of income or age. Program fees are on a sliding scale, and residents may elect to participate in the homecare program, the meal program or both. The social worker assists participants to gain access to other available

services, such as adult day care, senior nutrition centers, transportation, home health or chronic disease nursing, bathing, mental health counseling.

This program provides efficient as well as more effective services than before the program was established. The personal care/homemaker service is provided using the Shared Aide Model (see above). Because meals were made available to building residents, the Meals on Wheels program was able to stop deliveries to building residents, freeing up 12 to 15 meal slots, and thereby forestalling the creation of a waiting list for home delivered meals.

During fiscal year 1995, 70 residents participated in the program. The average age of participants was 82. Approximately 50 residents participate at any one time. The average length of time a resident participated in the program was 30 months. Ninety-five percent of the program participants have significant functional/health problems (e.g. diabetes, arthritis, cardiac problems, vision impairments, or memory loss).

D. SEVAMP Housing Service Coordination Program

Southeastern Virginia Areawide Model Program, Inc. (SEVAMP), is the area agency on aging in Norfolk, Virginia. The agency's Housing Service Coordination Program (HSCP) is not an attempt to replace existing services or the informal care offered to elders and persons with disabilities by friends or relatives, but rather intended to supplement these services with currently unavailable or inadequately provided services.

The HSCP is designed to alleviate property managers of the burden of direct provision of care and services. By shifting this responsibility to a Housing Service Coordinator, potentially dangerous situations may be recognized and eliminated before there is a need for crisis intervention. In cases where residents become functionally dependent, the program may be available, when necessary to assist management in finding more suitable placement while also avoiding inappropriate institutionalization. In addition, the HSCP may provide assistance to residents who need only temporary assistance such as might be the case of a resident who is injured in a fall and needs assistance with housekeeping chores.

Services which may be provided by the Housing Service Coordinator include case management, resource assessment and development, information and referral, entitlement application assistance, group educational program, peer support group development, access to community services, and assistance with relocation.

Since the implementation of the program in 1991, over 300 residents from four properties in three cities have benefited from the program. The average age of residents is 83 years old, having significant functional health problems , i.e.,

arthritis, diabetes, asthma, hypertension, cardiac problems, cancer, hearing/vision impairments, etc.

SEVAMP Housing Service Coordination Program is designed to ensure frail elders and persons with disabilities living in independent living facilities are able to maintain their independence in the community as long as possible. Acting as a liaison and/or advocate for the resident, the Housing Service Coordinator provides supportive services for this target population.

E. League of Older Americans Area Agency on Aging Melrose Towers Project

The Roanoke City Redevelopment and Housing Authority (RCRHA) operates Melrose Towers, a housing complex for elderly residents. The League of Older Americans Area Agency on Aging in Roanoke, Virginia (LOA AAA) has a satellite office at the complex and has a congregate meal site in the facility. By providing hot, nutritious meals five days per week, many residents at Melrose Towers have been able to continue to live independently.

In May, 1992, LOA AAA was awarded a grant from the United Way of Roanoke Valley to provide homemaker, personal care and counseling to elderly residents living in Melrose Towers. This inner-city complex was opened approximately 20 years ago with many senior citizens still residing there and aging-in-place.

In order for individuals to be assessed to remain in their apartments, the LOA AAA, Family Services of the Roanoke Valley and RCRHA united in the grant application to be able to provide necessary in-home services. The grant was awarded for one year, enabling the delivery of services in order to keep individuals in their apartments and out of nursing homes and adult care residences, which are more costly.

Services that were provided included: homemaker tasks, such as meal preparation and light housekeeping; personal care such as bathing and hygiene care; and counseling dealing with issues such as adjustment to aging and changing of physical condition. The focus of this program was to assist individuals on a short term basis. This was particularly helpful to individuals who were coming out of the hospital to receive services to help them to get back on their feet. In several instances nursing home placement was averted and the quality of life of individuals served by the program was improved. The LOA AAA provided case management and assisted in putting services in place. This project was not re-funded. The LOA AAA looked for other options for funding, but was not able to secure funding to continue this project.

X. ACCESS TO SERVICES THROUGH A FEE SCHEDULE

Fee schedules are being used in public and private service agencies to make needed services available to persons who cannot pay the cost of the services but who can contribute something toward the cost and to stretch limited funding to serve as many people in need as possible. The 1992 Virginia Acts of Assembly, Chapter 893, Item 292 provided funding to the Department for the Aging to implement a pilot program of cost-sharing. This project represented a philosophical change for the Department for the Aging as older persons have traditionally been offered the opportunity to contribute toward the cost of services provided through area agencies on aging but have not been charged for the services. Seven area agencies on aging participated in the pilot. Data demonstrates the projects to have been successful. While there was varying levels of success for the participating agencies, each agency accumulated comparatively more funds through collection of fees than previously received through collection of contributions. The final report for this project is included as Appendix J.

In the 1995 session of the Virginia General Assembly, state lawmakers established that any additional funds to Area Agencies on Aging must be used in services that assess consumer fees by including the following language in the fiscal year 1996 budget bill.

> *"It is the intent of the General Assembly that beginning in fiscal year 1996 all area agencies on aging, with any new general fund revenue, will implement sliding fees for services. Revenue generated as a result of fees shall be retained by the area agency on aging for use in meeting critical care needs of older Virginians."*

House Joint Resolution 564 requests that this study identify a sliding fee schedule through which at-risk citizens can access supportive services needed to support their continued independent living. The purpose of recommending a fee schedule is to make available resources accessible to the largest possible number of elders and persons with disabilities who need supportive services to remain independent. Cost sharing will have the advantage of accomplishing this and will also reduce cost to the state. A system which facilitates customer participation in choosing and financing needed supportive services increases customer satisfaction and alleviates the family's caregiving burden. Advancing the opportunity for the recipients of services to share in defraying the cost of the service is empowering for both the consumer and his family and increases the sense of responsibility and accountability for his own care.

The Virginia Health Department's schedule for determining eligibility for medical services is the scale used by several area agencies on aging for determining charges for in-home services. This scale is also used by the Case Management for Elderly Virginians Project. Some providers use the fee scale as a suggested contribution scale rather than a fee for services. The Virginia Health Department's fee schedule specifies

no charge for indigent patients and a modest 10 percent charge for the near indigent. Persons with annual incomes of $7,492 and greater are charged 25 percent, 50 percent, 75 percent and 100 percent depending upon level of gross income. The Health Department's scale is based on percent of unit cost. While this scale is practical for specific unit cost, e.g., an injection or office visit, it may not be practical for long-term in-home services that vary considerably in the number of hours authorized during a month.

Some agencies use a modified version of the Health Department's schedule with no charge for indigent persons and a flat hourly rate for other income groups, e.g., $1.20 per hour of service to the near indigent to $12.00 per hour for the highest income level. Based on the Virginia Department of Social Services' Annual Adult Services Survey for 1995, the average number of home-based care hour is 12 hours per week. Even with a flat rate of $1.20 per hour, 12 hours per week may put a burden on low-income residents. See Appendix K for a copy of the Virginia Health Department fee schedule.

XI. RECOMMENDATIONS

A. Supportive Services and Service Coordination

Supportive services which enable elders and persons with disabilities to maintain as much independence as possible for as long as possible is the preference of most residents and is an often stated goal of service providers. Tenants are frequently able to make their own arrangement for the delivery of supportive services without assistance. However, as the vicissitudes of old age and disabilities continue to limit functional abilities, the tenants' ability to arrange for needed services without assistance is diminished.

There is considerable support in the housing industry for assuming limited responsibility for making the link between the person who needs services and the service provider. Some housing projects in the Commonwealth provide service coordination. Generally the coordination occurs through the efforts of a staff person who is employed to work with tenants who need supportive services, to link them with the appropriate community service providers and to monitor the services that are provided.

○ *Recommendation 1*

The Commonwealth should explore more extensive use of service coordination in housing for elders and persons with disabilities by taking the following actions:

- Conduct a statewide feasibility study to examine the feasibility of implementing supportive services coordination in housing developments which target elders and persons with disabilities;

- Explore public/private partnerships to develop service coordination programs modeled after the Congregate Housing Services Program administered by the U. S. Department of Housing and Urban Development; and

- Initiate discussions with the Department of Housing and Urban Development to explore expanded funding under the Congregate Housing Services Programs to include the cost of service coordinations.

B. Independent Living Facilities and ACRs

Virginia's ACR industry is comprised of 572 facilities, licensed to provide care to 27,000 residents. The methods through which needed services are provided to elders and persons with disabilities have been a defining feature of residences which target these populations. The ACR assumes primary responsibility for assuring that needed services are delivered and for service coordination. When a vulnerable population is being planned for rather than being given information to plan for itself, the Commonwealth has an interest in assuring safeguards are in place to maximize safety and minimize opportunities for neglect of care.

In congregate housing, the "tenant" is there under the terms of a lease. There is no contract for services and no expectation that the housing property administration will assume responsibility for assuring service delivery. The individual is considered to be in an independent living arrangement and as such is responsible for making any arrangements for the delivery of services he/she needs. The Commonwealth has no interest in arrangements an adult makes for himself.

Researchers in aging issues tell us that for every elder who is in an institutional, long-term-care setting, there are two equally impaired elders living in the community. No doubt, many of those who are equally impaired are tenants in congregate housing for the elderly persons and persons with disabilities. When housing developments employ staff who are assigned responsibility for service coordination, the feature which differentiates and defines ACRs and assisted housing is less apparent.

○ *Recommendation 2*

The General Assembly should request that the Joint Commission on Health Care, as part of their current study under House Joint Resolution 637, address whether provisions of Chapter 9 of the Code of Virginia are relevant to independent living facilities and, if so, under what circumstances do those provisions become relevant.

C. Collaborative Efforts Among State and Federal Agencies Towards Linking Services to Housing

As the Commonwealth moves into the 21st century it will be faced with an ever-increasing aging population. How to meet the service needs of the frail elders and persons with disabilities living in subsidized housing will be a critical issue when considering how to efficiently expend public dollars. Collaboration among state human services agencies and state and federal housing agencies should be promoted, through use of cooperative agreements that speak to the service needs of frail tenants. Innovation, creativity and cost-effective approaches should be explored to assure that public dollars are available to help the target population remain independent in safe and affordable housing.

○ *Recommendation 3*

- The Commonwealth should support efforts that link services to senior housing developments, to include Medicaid waivered services.

- Virginia Housing Development Authority should be asked to explore the expansion of its housing training and staff development initiative to include non-VHDA senior housing developments.

- The Commonwealth should explore how the Office of Volunteerism can work with senior housing management to promote volunteerism, such as the creation and use of resident volunteer cooperatives to complement the delivery of more formal supportive services.

D. Sliding Fee Schedules

Cost sharing will have the advantage of reducing the cost to the state while making supportive services needed to remain independent, available to more elders and persons with disabilities. The consumer's participation in the service delivery process has been demonstrated to increase consumer satisfaction and alleviate family caregiving burden. The shared responsibility for one's care is empowering for both the service recipient and his family thereby increasing the consumer's sense of responsibility and accountability for his own well-being. The fee schedule can be a very flexible tool, collecting fees for services rendered while giving staff the option to waive fees in hardship cases and to vary fees from month to month depending on the individual's circumstances.

The cost of providing supportive services to persons in independent living facilities varies from locality to locality. Other local variables include, but are not limited to, the level of need for a specific service, the availability of

independent housing, the availability of service providers, and the cost of the services.

○ *Recommendation 4*

The Commonwealth should provide technical assistance to local service providers to develop a local fee schedule which reflects the uniqueness of the community. Local fee schedule should address:

- Definition of the target population and how eligibility will be determined;
- What specific supportive services will be delivered;
- A mutually agreed upon scale for all providers of in-home services within the community;
- Minimum income level at which a fee for services will be assessed (i.e., may elect to collect no fee for persons whose income is SSI or less);
- Whether a fee will be based on percent of unit cost or percent of gross income. (A percentage of gross income fee schedule would eliminate the added burden of revising fees based on change of need and authorized hours.);
- What specific deductions from gross income will be made before assessing the fee for services, (i.e., the cost of prescription medicines, the cost of rent or a percentage of the cost of rent, adult day care costs, other regularly reoccurring cost of maintaining the person in the community, etc.);
- Under what circumstances the fees will be waived;
- Under what circumstances the services will be suspended or terminated for non-payment of fees; and
- To whom the consumer shall pay fee (i.e. to the provider, to the agency).

E. Innovative Financing for Construction of Congregate Housing

Waiting lists and unmet needs for supportive housing in Virginia and in the nation is a documented phenomena. The first of the large post-World War II generations (the Baby Boomers) will turn 50 years old in 1996. This generation will be reaching the 60th birthday beginning in 2006 and continuing through 2024.

○ *Recommendation 5*

To better plan for housing needs of the next 50 years, the Departments of Social Services and for the Aging should consider a plan already in use in a number of other states. This should be preceded with an analysis to identify the areas of the Commonwealth in which the shortage of assisted housing is most acute now and projections of where shortages will be most acute in the next decades.

- Virginia Housing Development Authority should consider giving extra points to senior housing developers who provide service coordination for frail elders and persons with disabilities.

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1995 SESSION
ENGROSSED
APPENDIX A

LD3712112

HOUSE JOINT RESOLUTION NO. 564

AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Rules)
(Patron Prior to Substitute—Delegate Almand)
House Amendments in [ ] — February 4, 1995

Requesting the Departments of Social Services and for the Aging to study the provision of certain services to low-to-moderate income persons which will allow them to remain in independent living facilities.

WHEREAS, most of the older citizens in the Commonwealth desire to remain as independent and self-sufficient for as long as it is possible; and

WHEREAS, many of these individuals are in the low-to-moderate income bracket and reside in congregate housing which provides subsidies to reduce the costs; and

WHEREAS, in many cases these individuals need only minimal assistance which will allow them to care for themselves and prevent their relocation to more expensive alternatives; and

WHEREAS, many of these congregate housing facilities include a system of care which, at best, is a hodgepodge because of the nature of the program and funding streams and the inconsistent availability of many services through the locality; and

WHEREAS, it is to the advantage of the Commonwealth and to her citizens to avoid placement in more expensive care, not only in terms of dollars but also in terms of the maintenance of dignity and self-sufficiency for the client; and

WHEREAS, some of the state and federal programs which currently provide some services to the elderly are in jeopardy of either having their funding reduced or eliminated; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Departments of Social Services and for the Aging be requested to study the provision of certain services to low-to-moderate income persons which will allow them to remain in independent living facilities. The Departments are requested to consider and identify the services which are necessary to maintain our older citizens in the least restrictive home setting and to identify a system of funding, including a sliding fee schedule, through which at-risk citizens can access these services. [~~the provision of certain services to low-to-moderate income persons which will allow them to remain in independent living facilities.~~]

All agencies of the Commonwealth shall provide assistance to the Departments, upon request.

The Departments shall complete their work in time to submit their findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates | Clerk of the Senate

APPENDIX B

POVERTY STATUS OF OLDER VIRGINIANS
1990 CENSUS DATA

BOTH SEXES

	Above Poverty	Below Poverty	Percentage Below
60 to 64	220,094	22,561	9.3
65 to 74	350,173	45,752	11.6
75 years and older	188,291	42,818	18.5

MALE

	Above Poverty	Below Poverty	Percentage Below
60 to 64	104,659	7,844	7.0
65 to 74	158,442	13,887	8.1
75 years and older	69,372	10,350	13.0

FEMALE

	Above Poverty	Below Poverty	Percentage Below
60 to 64	115,435	14,717	11.3
65 to 74	191,731	31,865	14.3
75 years and older	118,919	32,468	21.4

SOURCE: Virginia Employment Commission, Economic Information Services Division. July, 1995

APPENDIX C

SECTION 202
HOUSING FOR THE ELDERLY & PERSONS WITH DISABILITIES

Anetta M. Lane
2734 Gatehouse Road
Norfolk VA 23504
40 units

Belleville Senior Housing
5520 Towne Point Road
Suffolk VA 23435
49 units

Beth Sholom Sands
6405 Auburn Drive
Virginia Beach VA 23464
120 units

Beth Sholom Woods
2027 Lauderdale Road
Richmond VA 23233
12 units

Burke Lake Gardens
9608 Old Keane Mill Road
Burke VA 22015
100 units

Calvary Towers
848 East Virginia Beach Blvd.
Norfolk VA 23504
112 units

The Carlin
1300 North Carlin Road
Arlington VA 22203
162 units

Chesterfield Square Homes
017 Hioaks Road
Richmond VA 23225
75 units

Claridge House
1500 South Fern Street
Arlington VA 22202
300 units

Covenant Place
101 Cedar Street
Smithfield VA 23430
40 units

Culpepper Garden*
4435 N. Pershing Drive
Arlington VA 22203
273 units

Edinburgh Greens
129 Hershberger Road
Roanoke VA 24012
40 units

Edinburgh Square
129 Hershberger Road
Roanoke VA 24012
96 units

Elm Manor
32 Elm Avenue SW
Roanoke VA 24016
23 units

Elmwood House
550 North Madison Street
Arlington VA 22203
50 units

Epworth Manor
P. O. Box 1398
Louisa VA 23093
61 units

Evergreen House
6925 Columbia Pike
Annandale VA 22003
246 units

Frederick House
4217 Lakeridge Drive
Stephens City VA 22655
47 units

Gillhaven Manor
514 Farmer Street
Petersburg VA 23802
101 units

Heritage Acres VI
Route 154 & Randolph Street
Cape Charles VA 23310
98 units

Heritage Haven
1501 Virginia Avenue
Harrisonburg VA 22801
150 units

Hilltop Gardens
2526 North Main Street
Danville VA 24540
41 units

Hunters Wood Fellowship House
2231 Colts Neck Road
Reston VA 22091
224 units

Kemet Manor
2139 Broadmoor Avenue
Chesapeake. VA 23323
38 units

SECTION 236
HOUSING FOR THE ELDERLY & PERSONS WITH DISABILITIES

Section 236 funding is provided by the U. S. Department of Housing and Urban Development for construction and rental assistance for low to moderate income families. Section 236 properties can be designated for elderly persons or mixed populations, such as families with children.

Annie B. Rose
(formerly Pendleton House)
399 Pendleton Street
Alexandria VA 22314
90 units

Cogic Memorial
2112 E. Virginia Beach Blvd.
Norfolk VA 23504
150 units

Essex House
375 South Reynolds Street
Alexandria VA 22304
209 units

John Knox Towers
1210 Colonial Avenue
Norfolk VA 23517
150 units

Landmark Apartments
5380 Holmes Run Parkway
Alexandria VA 22304
159 units

Leesburg Village
807 K Edwards Ferry Road
Leesburg VA 22075
156 units

Loudoun House
715-16 Edwards Ferry Road NE
Leesburg VA 22075
248 units

Old Towne West
431 South Columbus Street
Alexandria VA 22314
172 units

Shenandoah Homes (HUD-HELD)
5300 Hawthorne Road NW
Roanoke VA 24012
143 units

Tysons Towers
8500 Tyspring Street
Vienna VA 22182
274 units

Lafayette House
11 South Sycamore Street
Petersburg VA 23803
100 units

Lake Anne Fellowship House*
11450 North Shore Drive
Reston VA 22090
240 units

Lakeridge Fellowship House
12800 Harbor Drive
Woodbridge VA 22192
99 units

The Lewisville
1515 Great Falls Street
McLean VA 22101
144 units

Liberty Park-Grace Place
2735 Corprew Avenue
Norfolk VA 23504
3 units

Lockwood House
600 North Madison Street
Arlington VA 22203
99 units

Luther Crest
9138 Congress Street
Shenandoah VA 22844
40 units

Luther Manor
350 Malibu Drive
Virginia Beach VA 23452
123 units

Madison House
25 Monroe St., SE
Leesburg VA 22075
100 units

Marywood
10700 Crestwood Drive
Manassas VA 22110
127 units

Marywood
1261 Marywood Lane
Richmond VA 23229
113 units

McGurk House
2425 Tate Springs Road
Lynchburg VA 24501
89 units

McKendree Manor
101 McKendree Court
Fredericksburg VA 22406
23 units

The Meadows
5800 Meadows Drive
Crozet VA 22932
57 units

Mount Hermon Elderly
2400 Cutherell Street
Portsmouth VA 23707
175 units

New River House
Warm Hearth Village
Blacksburg VA 24060
42 units

Parkview of Radford
103 Duncan Lane
Radford VA 24141
13 units

Ridgecrest
20 Knollridge Road
Salem VA 24153
106 units

Scott Hill
800 West Ridgeway Street
Clifton Forge VA 24422
95 units

Seton Manor
215 Marcella Road
Hampton VA 23666
112 units

Spring Knoll Manor
101 McKendree Court
Fredericksburg VA 22406
23 units

Sts. Cosma & Damiands
House
German School & Glenway Dr
Richmond VA 23229
35 units

The Russell House
900 First Colonial Road
Virginia Beach VA 23454
119 units

Timberlake Village I
Cedar Avenue Ext.
Farmville VA 23901
15 units

Trolinger House
Warm Hearth Village
Blacksburg VA 24060
102 units

Tucker House I
7700 Armfield Avenue
Norfolk VA 23505
80 units

Tucker House II
7700 Armfield Avenue
Norfolk VA 23505
48 units

William Watters House
22365 Enterprise Street
Sterling VA 22164
90 units

Woodland Hill
610 South Carlin Springs Road
Arlington VA 22204
235 units

* Section 202/236

9/5/95

APPENDIX D

Section 8 Rental Assistance Program

Voucher and Certificate Programs

The Section 8 program is administered via certificate or voucher. HUD provides rental assistance to elders and to low-income families through its Section 8 housing voucher and certificate programs. Vouchers, which were established in 1983, and certificates, which were established in 1974, provide rental subsidies to make decent, safe, privately owned rental housing affordable to low-income families. A primary distinction between the voucher and certificate programs is the way in which public housing agencies (PHA) compute the amount of rental assistance. This difference, in turn, can affect the family's rent burden. Both vouchers and certificates are "portable." Under certain circumstances they may be transferred from one part of the country to another, should an assisted family wish to move.

For years Section 202 projects were developed with project specific, 20 year, 100 percent Section 8 rental assistance contracts. New 202s are now developed as grants. Instead of using Section 8 as a method to provide subsidized rents to residents, *Project Rental Assistance Contracts* (PRACs) are being used to provide rental assistance.

The voucher and certificate programs differ in the way in which the federal subsidy available to participants is calculated. Federal subsidies under the certificate program are based on the actual rent paid to a private landlord. Rent must be less than or equal to the local fair market rent (FMR) set by HUD and must be deemed reasonable by the PHA in terms of the local rental market. The assisted family pays 30 percent of its adjusted monthly income for rent and the PHA pays the landlord the difference between the tenant's payment and the approved monthly rent. If the rent does not meet these criteria, the PHA may disapprove the lease and the family will have to find a different unit (U.S. GAO, March 1993).

Federal subsidies under the voucher program are computed on the basis of a specific payment standard, which is based on the published Section 8 FMR and is established by unit size for each market area. The PHA generally subtracts 30 percent of the family's monthly adjusted income from this standard to arrive at the monthly housing assistance payment. Voucher holders may lease units with rents below or above this standard; however, subsidies are based on the payment standard regardless of the actual rent on the unit.

Section 8 units must meet HUD's housing quality standards. The intent of these standards is to establish minimum criteria necessary for the health and safety of occupants. Performance requirements and acceptability criteria are set for elements such as sanitary facilities, heating and cooling systems, illumination and electricity, both on-site and in the neighborhood where the unit is located. Before approving a lease, the PHAs are required to inspect the unit to ensure compliance with these standards. Thereafter, the PHAs are required to inspect every unit at least annually to ensure that the owner is (1) maintaining the unit in decent, safe, and sanitary condition, and (2) providing the agreed upon utilities and other services.

APPENDIX E

Congregate Housing Services Programs (CHSP)

The CHSP began as a demonstration program in 1978 to provide congregate housing and coordinated supportive services for elders and persons with disabilities. CHSPs became permanent in the 1987 Housing Act but availability is limited to 2,000 elders and persons with disabilities in public and nonprofit housing. An estimated 105,000 are in need of the program (The National Eldercare Institute on Housing and Supportive Services, December, 1992). Section 802 of the 1990 National Housing Act created a new revised CHSP which was later amended by Section 604 and 672 of the Housing and Community Development Act of 1992. The revised CHSP has two components: a retrofit/renovation component and a supportive services component. The costs of CHSPs are shared. Residents receiving services pay ten percent, the grantee or third party(ies) pay 50 percent, and HUD will pay up to 40 percent.

CHSPs, which include some *Retirement Service Centers* insured by HUD, provide an effective alternative to institutional care for many elders and persons with disabilities, especially when supportive services are targeted to those who are most vulnerable. Housing sites that have CHSP in place are more likely to admit persons who would otherwise be placed in institutional care but who want to live in a setting that allows more independence. The majority of participants in CHSPs are widowed and roughly one-third are childless. A listing of Retirement Services Centers in Virginia follows this program description. Retirement Services Centers operate at fair market rental rates, having no significant impact on older low-to-moderate income renters.

CHSP projects must provide at least one meal a day for some or all of the participants, and offer one or m of the following, as appropriate to the residents: housekeeping, personal care services, transportation, non-medical supervision, wellness programs, preventive health screening, monitoring of medication consistent with state law, personal emergency response systems and other supportive services, as approved by HUD. Such services must be geared specifically to the needs of each participant and voluntarily offered and accepted.

The CHSP has been a critical service to family caregivers of elders and persons with disabilities. A survey of CHSPs found that informal family involvement was maintained and strengthened by the implementation of the program, preventing families from becoming overburdened with caregiving responsibilities. This program provides an important link in a continuum of service options ranging from fully independent community living to institutional care. Providing this link will require the integration of housing, social services, and long-term care services (U.S. House of Representatives Select Committee on Aging, 1987).

The CHSP is a cost-effective means for delivering services to frail elders and persons with disabilities. A report by the U. S. Select Committee on Aging indicated that a carefully targeted program can save the taxpayers' money over institutional and other forms of care. The most careful cost comparison study estimates these savings to be from $4,233 to $5,880 per person per year. Most of the service time (67%) and expense (54%) was found to be in the provision of meals (U.S. House of Representatives Select Committee on Aging ,1987).

The Select Committee report further revealed that the CHSP was found to utilize existing service programs in the community, thus allowing existing service programs to maintain their efforts to provide formal servi Local CHSP coordinators were found to be effective in mobilizing a range of existing services to supplem... CHSP services. The CHSP has a substantially positive effect on the life satisfaction of its participants.

APPENDIX F

SURVEY OF HUD SECTION 202 PROPERTIES
CURRENTLY PROVIDING ON-SITE SUPPORITVE SERVICE COORDINATION

How many of your residents (percentage) would you estimate currently receive supportive services on a regular basis? Supportive services include such activities as service coordination/case management, meal services, personal care assistance housekeeping assistance, counseling, transportation services and health related services.		
Beth Sholom Woods	Lafayette House	William Plummer Plaza
Approximately 100%	Service Coordination 100% Transportation 35% Personal Care/Housekeeping 15% Meals Services 95%	17 of 53 residents

What supportive services are most frequently used by residents?		
Beth Sholom Woods	Lafayette House	William Plummer Plaza
Meals Transportation Housekeeping Case Management Home Health	Transportation Health Related Services Meals on Wheels Housekeeping Assistance is frequently needed, but difficult to obtain.	Personal Care Housekeeping

How do residents pay for the services they use?		
Beth Sholom Woods	Lafayette House	William Plummer Plaza
Except for case management and short term counseling which are provided by service coordinators, the residents pay for services out-of-pocket.	Sliding fee schedule, and fixed fee amounts designated by the agency providing the service. Also personal pay from the residents income.	Medicare and Medicaid

Please provide information on your system of funding for the provision of supportive services e.g., residents pay for services, sliding fee scale, services subsidized by community/corporate/civic/advocacy sponsors.		
Beth Sholom	Lafayette House	William Plummer Plaza
Residents pay for services. Service coordinators attempt to link residents to agencies offering subsidized fees.	All of the above	Food provided by SEVAMP (Area Agency on Aging). to Temple Beth El. Residents pay fifty cents.

What gaps in services do you believe currently exist in your community's service delivery system (What services do your residents need that are not available in the community) ?

Beth Sholom Woods	Lafayette House	William Plummer Plaza
High Quality and affordable assisted living facilities and services follow income individuals who can no longer live independently and do not meet nursing home criteria. Public transportation would promote active and involved senior community members. Their quality of life, sense of independence and level of productivity would increase drastically. Affordable medication management for seniors who are independent in all activities except the daily administering of medication.	Transportation to physicians and medical facilities in Richmond, Colonial Heights, and Hopewell if the resident is not on Medicaid Extended. Extended wait or delay, or rejection on services that require immediacy. The cause given, " Lack of funding." Housekeeping services that are almost non-existent at this time. Reason given: lack of funding.	Residents have to pay for transportation and companion services.

Please Indicate the number of households in your property currently receiving Section 8 rental assistance.

Beth Sholom	Lafayette House	William Plummer Plaza
110	100	49

Who are the primary providers of the supportive services delivered to your development (family, human service agencies (DSS, local Mental Health Center), Legal Services, in-home care providers, area agencies on aging, etc.?

SERVICE	Beth Sholom Woods	Lafayette House	William Plummer Plaza
Service Coordination, Case Management	On-site service coordinator	On-site service coordinator	On-site service coordinators
Meal Service	Facility has a food plan	Crater District Area Agency on Aging (CDAAA)	Temple Beth El
Personal Care Assistance	A Variety of home health, personal care providers	In-home care providers	Home Care of Suffolk, Suffolk Health Department
Housekeeping Assistance	Jewish Family Services	CDAAA, In-home care providers	Home Care of Suffolk, Suffolk Health Department
Counseling	On-site Service Coordinators	On-site Service Coordinators, District 19 Mental Health Services	First American Home Care, On-site Service Coordinator
Transportation Services	Star, Transco, Jewish Family Services, Beth Sholom Van	CDAAA, American Red Cross (discontinued 6/30/95 due to lack of funds	
Health Related Services	A Variety of home health, personal care providers	CDAAA, In-home care providers	First American Home Care
Other (please specify)		Va. Dept. for the Visually Handicapped	

Supportive Services Program in Senior Housing

Program Summary

In November 1988, Virginia Housing Development Authority (VHDA) was selected by the Robert Wood Johnson Foundation as one of ten state housing finance agencies to participate in the Supportive Services Program in Senior Housing. Under this Program, VHDA is being awarded grant funds over a three-year period to assist in the development of innovative, affordable, and efficient means of delivering supportive services to older people living in Authority financed subsidized housing developments for the elderly.

This national initiative is a joint undertaking of the Robert Wood Johnson Foundation, the nation's largest health care philanthropy, and the National Council of State Housing Agencies (NCSHA) to meet the needs of an aging tenant population. The Foundation and NCSHA are providing technical assistance for this Program to Virginia Housing. Virginia Housing, in turn, is providing support and assistance through its Housing Management Division to owners and managers of elderly housing developments throughout Virginia. Nine senior housing developments are participating in Phase I of the Program. An additional fifteen developments are expected to participate in Phases II and III. Ms. Terry Fuhr, Housing Management Officer, is the contact person at VHDA.

Background

Of the 700,000 older Virginians, 17,000 to 18,000 live in senior housing developments that receive public assistance. As these developments have aged, so too have their resident populations. This "aging in place" phenomenon has led to an increase in the need for supportive services that will enable residents to maintain their independence and self-sufficiency. If these needs are not met, the quality of life in the housing community will be affected, not only for the resident in need of assistance, but also for other residents. Elders not able to accomplish certain tasks of daily living may become frustrated, apathetic, and isolated or, alternatively, turn to their friends and neighbors for support and assistance. Such informal support networks by and large account for 75 to 80 percent of the care that older people receive.

The isolation that may result from unmet needs can result in alcoholism or abuse or misuse of prescribed medications that paves the way for property damage and life-threatening situations. While the informal support networks can help to combat such problems, too much reliance on such forms of assistance may not adequately meet the needs of the individual, and may put intolerable strain on the care givers, particularly if they themselves are elderly.

The Supportive Services Program is not an attempt to replace existing services or the informal care offered by friends or relatives, but rather intends to supplement these with services currently unavailable or inadequately provided. By doing so, potentially dangerous situations may be recognized and eliminated before there is a need for crisis intervention.

How the Program Works

Selection of Services to be Provided

The services to be offered and the frequency of delivery depends on resident desires and needs, as well as costs. Examples of services which may be offered are: housekeeping, transportation, meals, shopping assistance, companion services, socialization/recreation activities and financial management.

Before a Services Program is developed for a housing development, Virginia Housing employs an independent consultant to perform a market survey of the desires and preferences of the residents. The survey used is provided by the Robert Wood Johnson Foundation. The same survey instrument is being used in all participating developments across the county in order to establish a national database on senior citizens living in subsidized housing. This survey relies on in-depth personal interviews with between 50 and 60 residents of each development. The results of the survey are used to help design a unique program that will address the needs and desires of the residents.

Design and Development of Services Programs

The design and development of service delivery models for participating housing developments involves a unique working partnership of owners and managers, tenants, local Area Agencies on Aging (AAAs), and Virginia Housing. Owners and managers have primary responsibility for program design, development, and implementation. Tenants provide input into the design process through the market survey, focus groups, and resident representation on the program design committee. AAAs assist in program design by sharing their special knowledge about the elderly and the community resources that serve them. Virginia Housing acts in an advisory role, providing technical assistance as needed, as well as contracting for marketing surveys of resident populations. In addition, VHDA serves as a liaison between the housing developments and the National Program Office for the Supportive Services Program in Senior Housing.

Provision of Services

Services may be provided or coordinated by community agencies, agency vendors, private contractors, volunteers or on-site personnel. In addition, local Departments of Social Services and Area Agencies on Aging may be involved in the coordination of services.

Eligibility for Services

All residents will be eligible, however, the availability of some services may be limited. In such instances, persons with the greatest need will be given priority for the service. Virginia Housing will assist housing mangers in developing guidelines for determining eligibility. In all cases, participation by residents will be voluntary.

Payment for Services

Because of the concentration of elderly in participating developments, there is an opportunity to take advantage of economies of scale so as to make the provision of services more efficient and affordable. The costs of services will be underwritten by a combination of fees paid by the service recipients (residents), contributions or subsidies provided by the housing development, and community resources. If the Supportive Services Program is to be sustained, then this unique partnership must succeed. Virginia Housing believes that this can happen if each of the parties recognizes the benefits it both receives and provides from its participation.

Education, Training and Marketing

In order for the Supportive Services Program in Senior Housing to be successful, there must be acceptance and support from the tenant population, as well as from owners and managers of housing facilities. Many elderly residents of subsidized rental housing are reluctant to admit a

need for certain services for fear that they will be labeled as frail and possibly evicted. Other residents, as well as owners and managers, may resist the introduction of services because they fear that to do so will change the concept of an independent living facility. Therefore, an important element of the Program is education, training, and marketing.

In November 1988, Virginia Housing initiated an educational program for owners and managers by co-sponsoring with the Department on Aging, the statewide "Conference on Senior Housing Management." A second conference is being held in the Spring of 1990. Through a continuing educational program, Virginia Housing hopes to sensitize owners and managers to "aging in place" and the importance of supportive services to resident well-being.

Program Benefits

Many frail elderly people can continue to function in their communities if appropriate supportive services are available. The Supportive Services Program is intended to provide elderly persons capable of independent living with the services they need and desire in order to enhance their continued independence and self-sufficiency. Some residents can expect to receive services on an ongoing basis. For others, the Program may provide only temporary assistance such as might be the case if they were injured by a fall and needed assistance with housekeeping chores while recuperating.

The Supportive Services Program is designed to alleviate management of the burden of direct provision of care and services, and reduce the need for crisis intervention. In cases where residents become functionally dependent, the program may be available when necessary, to assist management in finding more suitable placement while also avoiding inappropriate institutionalization. The Supportive Services Program will continue to promote educational and training opportunities for managers, and will seek to coordinate increased interaction between management and community resources.

A primary goal of the Supportive Services Program is to develop new ways of financing the delivery of services to the elderly. AAAs that participate in this program may be able to serve more members of the senior community without incurring additional costs. One of the potential benefits of this Program is that it represents an opportunity to take advantage of the economies of scale afforded by concentrations of older persons in one location. In some cases, additional staff personnel may be hired by the housing owner or manager to work as Program Coordinators or Consultants which would, in effect, provide AAAs with adjunct staff at the apartment community.

APPENDIX H

RESULTS OF SURVEY OF VIRGINIA HOUSING DEVELOPMENT AUTHORITY SENIOR HOUSING DEVELOPMENTS JUNE, 1995

Percentage of Residents Receiving Services	
High Score	80%
Low Score	2%
Average Score	32%
Services Typically Provided By:	
Agencies	24
Family	15
Housing Staff/Service Coordinators	7
Community/Senior Center	4
Types of Services Regularly Used by Residents:	
Housekeeping Assistance	16
Meals/Meals on Wheels	15
Transportation	10
Personal/Companion Care	9
"Home Health" Services	6
Shopping Assistance	3
Perceived Gaps in Service Availability:	
Transportation	12
Housekeeping Assistance	12
"Affordable Service for Non-Indigent Elderly"	7
Crisis Assistance with Alcohol/Drug and Mental Health Matters	3
Adequate Follow-up after Hospitalization and with Agency-Provided Services	3
Means of Payment for Support Services:	
Sliding Scale (based on income/ability to pay)	18
Medicare/Medicaid	3
Housing/Resident Co-payments	6
Family Assistance	2

**In each grouping, N=24; Total for each group is greater than 24 due to multiple responses.*

APPENDIX I

OTHER STATE SPONSORED SENIOR HOUSING INITIATIVES

A. Congregate Housing Program (CHP)

Virginians with low incomes and special needs are more likely than other citizens to find themselves living in inadequate or poor quality housing. Lower-income persons with specials needs often require costly supportive services or physical adaptations to their housing. In order to help people with special needs live independently and with dignity, the Virginia Housing Partnership Fund has created the Congregate Housing Program.

The Congregate Housing Program (CHP) is designed to increase the supply and improve the quality of housing available to low-and-moderate income residents with special needs, including the frail elderly, people with mental and physical disabilities, recovering substance abusers, or children in the care of the state.The CHP offers financing for the capital costs of creating or improving housing that provides services to people with special needs.

Applicants must identify the special needs population they expect to serve and provide a description of the supportive services they will offer to the proposed target population. During evaluation of the proposals, preference is given to projects serving the frail elderly, people with mental and physical disabilities, recovering substance abusers, and children. Sponsors are expected to continue to serve the designated special needs population(s) throughout the funding term.

The CHP is designed to finance the capital costs of housing with supportive services for people whose primarily need is foe non-medical assistance to maintain their independence. The supportive services provided should be specifically oriented to meeting the special needs of the targeted population. While DHCD will evaluate proposed services as part of the review process, no services may be funded through the Congregate Housing Program.

Eligible applicants for the Congregate Housing Program include non-profit corporations; units of local government; public housing authorities; and for-profit individuals, partnerships and corporations. See **APPENDIX M** for a listing of housing funded under the Congregate Housing Program.

B. Low Income Housing Tax Credit Program

The Internal Revenue Code of 1986 provides for tax credits to owners of residential rental projects providing low-income housing units. The credits are taken annually for a term of ten years, beginning with the tax year in which the project is placed in service or, at the owner's election, the next tax year. Twenty percent of the units in the project must be occupied by tenants whose incomes are 50 percent or less of the area median gross income, as adjusted for family size, or 40 percent or more of the units in the project must be occupied by tenants whose incomes are 60 percent or less of such area medium gross income, as so adjusted. Family size adjustments are to be made according to a HUD formula. Those units which are subject to such income restrictions are termed "low-income units." The Low Income Housing Tax Credit Program is administered by the Virginia Housing Development Authority. See **APPENDIX N** for a listing of projects receiving tax credits from this program in 1994.

C. Tax Exemption Bond Financing

Tax exemption bond financing for construction of congregate facilities is available in Virginia through VHDA's Multi-Family Loan Program. But this form of financing is not widely utilized because it is difficult to implement without other forms of subsidy, such as Section 8 or tax credits. This form of financing for congregate housing is also available in Arkansas, Idaho, Illinois, Pennsylvania, North Carolina, Ohio, and Oregon.

D. Rent Reduction State Tax Credit Program

The purpose of the Rent Reduction State Tax Credit Program is to increase and preserve the supply of affordable housing for seniors and persons with disabilities while helping owners of rental properties fill vacant units and/or offer other affordable rents to current residents. It also provides for an owner who has been renting a unit below market rent to receive credit for continuing to offer affordable housing.

Rental property owners who participate in this program, agree to discount rents by at least 15 percent of the market rent. In exchange, they receive 50 percent of the discount back in the form of a state tax credit. For example, if 10 units are reduced by $100/month and are occupied for 12 months, the owner would receive a tax credit of $6,000 ($100 x 10 units x 12 months = $12,000; $12,000 x 50% = $6,000).

This is a credit, not a deduction. It comes directly off of the bottom line of the amount of income tax owed the state. The credits can be carried over for a period of five years, but are only applicable to the owner(s). They cannot be sold or transferred.

There are benefits for owners other than receiving tax credits. By making affordable housing available to seniors and persons with disabilities, the owner can lease units that would otherwise remain vacant. Affordable rents allow managers and owners to develop a relationship with community service organizations which serve as no-cost referral resources and provide a ready source for locating new residents.

Persons eligible for the program must be at least 62 years old or have a disability. The household must have an income of no more than 80 percent of the median income for the area. The reduction can be offered to new residents or to in-place residents who may be finding it difficult to make ends meet on a fixed income.

Program usage data from August, 1994, revealed the following:

- 346 households out of a total 641 household served have received discounted rent of at least 15 percent and as much as 59 percent of the market rent, with the average reduction being 23% of the market rent. (The eligibility of the remaining 295 households served was based on the disability of a household member.)

- Usage was highest in the Roanoke/Lynchburg/Danville area, the Richmond area and Tidewater area.

  The type of housing in the program is predominantly apartment units, with single-family housing units being used almost exclusively in rural areas.

- Many of the household benefitting from the program were "in-place" residents. The owner of the rental property may have used the program participation either as a means to avoid a rent increase or to re the household's current rent.

The Rent Reduction State Tax Credit Program is administered by the Virginia Housing Development Authority. This program is scheduled to sunset December 31, 1996. A listing of current participants can be found in **APPENDIX O.**

Virginia Department for the Aging

FEE FOR SERVICE PILOT PROGRAM

July 1, 1994-June 30, 1995
Final Report

Background

For fiscal year 1995, seven Area Agencies on Aging (AAAs) participated in the Fee for Service Pilot Program. Participation in this program was entirely at the discretion of the AAA. After a low level of two AAA participants in this program in its first year, the Department worked closely with the AAAs to revise requirements and procedures. The application process and reporting requirements were significantly streamlined, providing greater flexibility and increased AAA participation. Of the $250,000 available, $186,194 was obligated to the seven AAAs.

Analysis

Attached is a two-part chart, consisting of Program Description and Program Analysis. Program Description shows the year-end total data reported by the seven projects. Program Analysis shows some comparisons to assist in analysis of those data. It is important to note that three of the projects, PSAs 2, 7, and 15, began operating October 1, 1994, therefore, their statistics represent nine months of program operation.

Definitions

An explanation of some of the terms in the charts will help clarify their meanings.
"Clients Paid" includes clients who have paid in full as well as clients who have paid only a portion of their bill.
"New" in the "Collections Per Unit" and "Collection Rate" sections refers to the service being delivered in this current project.
"Old" in the "Collections Per Unit" and "Collection Rate" sections refers to the same service delivered in a prior year under other funding sources that did not charge fees, but allowed voluntary contributions. When an agency has not previously provided the service under a non-fee funding source, we have used statewide data for comparison with that service; otherwise, we have used data from the individual agency.
"Collections" means fees as well as any voluntary contributions when used alone or with "New" and means voluntary contributions only when used with "Old."

The Program Analysis chart shows "Collections Per Unit" were higher across the board in this project than in non-fee services at year-end. "Payment Rate" shows an average

- OVER -

of 97% of the amounts billed were collected. "Payment Rate" for individual agencies ranged from 29% to 101%. The average of 89% for "Participation Rate" indicates a majority of clients paid all or a portion of the amounts they were billed. "Participation Rate" for individual agencies ranged from 43% to 100%. "Collection Rate" shows the ratio of collections to expenditures in this pilot project was significantly better than in non-fee services at year-end. The average collection rate for this project was 44%, with a range of 2% to 96%. The average collection rate for non-fee services was 3%, with a range of 0% to 7%.

Summary

Overall, the year-end data show the projects have been successful. While there have been varying levels of success for individual agencies, each agency has accumulated comparatively more funds through collection of fees than have previously been received through collection of contributions. Overall, the payment rate, i.e., the ratio of amounts billed to fees paid, is just over 97%. The percentage of clients billed who paid all or some portion of their billed amounts went up over the course of the year, with paying clients still in the majority at 89%. The year-end data also show collections covered an average of 44% of expenditures, as compared to an average of 3% of expenditures covered by voluntary contributions in the previous fiscal year. Finally, when we correct for one agency's extremely high amount of fees collected (over 14 times the amount of their grant), the data show the purchasing power of the General Fund dollars was increased, on average, around 20%.

PROGRAM DESCRIPTION													
		PSA 2*	PSA 4	PSA 7*		PSA 8C	PSA 9	PSA 9**	PSA 9	PSA 13	PSA 13**	PSA 15*	Statewide Total
Contract Amount		$2,000	$18,219	$20,000		$80,975	$25,000			$10,000		$30,000	$186,194
COMPANION	hours						356						
	persons						3						
HOME HEALTH	hours			262									
	persons			8									
HOMEMAKER	hours	369				4,514		1,548		3,011			
	persons	9				103		11		22			
PERSONAL CARE	hours				834				2,668		7,770	2,312	
	persons				22				20		19	45	
TRANSPORTATION (medical)	miles		87,971										
	persons		150										
	one-way trips		3,530										
Clients Screened		9	235	8	22	103	3	11	20	22	19	45	
Clients Billed		9	93	4	13	42	1	8	14	22	19	45	270
Clients Paid		6	93	4	11	33	1	4	6	22	19	41	240
Total Fees Billed YTD		$279	$8,033	$269	1,872	$15,216	$125	$1,836	$3,212	$13,465	$131,070	$6,015	$181,392
Total Fees Collected YTD		$279	$8,022	$93	1,710	$15,436	$125	$545	$939	$13,465	$131,070	$4,584	$176,267
Expenditures	Grant	$2,000	$18,219	$6,000	14,000	$80,975	$2,135	$8,531	$14,334	$5,000	$5,000	$30,000	$186,194
	Fees	$279	$8,022	$93	1,710	$15,436	$125	$545	$939	$13,465	$131,070	$4,584	$176,267
	Federal	$0	$6,723	$0	0	$0	$0	$0	$0	$0	$0	$0	$6,723
	Non-Federal	$471	$1,462	$0	0	$24,784	$224	$1,752	$3,395	$0	$0	$0	$32,089
	TOTAL	$2,750	$34,426	$6,093	15,710	$121,195	$2,484	$10,828	$18,668	$18,465	$136,070	$34,584	$401,272
PROGRAM ANALYSIS													
Collections Per Unit	1. Collections New÷Hours New	$0.76		$0.35	$2.05	$3.42	$0.35	$0.35	$0.35	$4.47	$16.87	$1.98	
	2. Collections Old÷Hours Old	$0.53		$0.00	$0.46	$0.53	N/A	$0.23	$0.00	$0.31	$0.21	$0.08	
	1. Collections New÷Miles New		$0.09										
	2. Collections Old÷Miles Old		$0.04										
Average Paid	3. Collections÷Clients Paid	$46.47	$86.26	$23.16	$155.43	$467.76	$125.00	$136.25	$156.50	$612.05	$6,898.42	$111.79	
Payment Rate (%$)	4. Collections Received÷Amount Billed	100.00%	99.86%	34.45%	91.34%	101.45%	100.00%	29.68%	29.23%	100.00%	100.00%	76.20%	97.17%
Participation Rate (%People)	4. Clients Paid÷Clients Billed	66.67%	100.00%	100.00%	84.62%	78.57%	100.00%	50.00%	42.86%	100.00%	100.00%	91.11%	88.89%
Collection Rate (%$)	5. Collections New÷Expenditures New	10.14%	23.30%	1.52%	10.88%	12.74%	5.03%	5.03%	5.03%	72.92%	96.33%	13.25%	43.93%
	6. Collections Old÷Expenditures Old	6.94%	7.30%	0.00%	2.61%	3.08%	N/A	3.06%	0.00%	2.90%	2.39%	0.58%	2.53%

Footnotes:

Based on Fee For Service Quarterly Reports ending June 30, 1995, and FMS data ending FY 93 and FY 94

* Fee For Service porgrams for these agencies started October 1, 1994 (others began July 1, 1994)

** Program Analysis data (Old) based on statewide average (other services based on individual agency service data)

1. Average dollar amount collected for each unit of service (hour or mile) under fee for service program (New).
2. Average dollar amount collected for each unit of service (hour or mile) under prior year's voluntary contribution system (Old).
3. Average amount paid by each client who paid for service under fee for service program.
4. Percentage of dollars collected versus dollars billed or clients paid versus clients billed under fee for service program.
5. Percentage of dollars collected versus total program expenditures under fee for service program (New).
6. Percentage of dollars collected versus total program expenditures under prior year's voluntary contribution system (Old).

CHART 1
HEALTH DEPARTMENT INCOME LEVELS
FOR DETERMINING ELIGIBILITY FOR MEDICAL SERVICES
EFFECTIVE JULY 1, 1995

No. IN FAMILY	INDIGENT PATIENTS	NEAR INDIGENT PATIENTS					INCOME LIMITS FOR WIC
	GROSS INCOME	GROSS INCOME	GROSS INCOME	GROSS INCOME	GROSS INCOME	GROSS INCOME	GROSS INCOME EFFECTIVE JULY 1, 1995
	LEVEL A - No Charge	LEVEL B - 10% Charge	LEVEL C - 25% Charge	LEVEL D - 50% Charge	LEVEL E - 75% Charge	LEVEL F - 100% Charge	BASED ON 185% OF POVERTY
1	Annual $0 - $7,470 Monthly $0 - $622 Weekly $0 - $143	$7,471 - $8,217 $623 - $684 $144 - $158	$8,218 - $9,958 $685 - $829 $159 - $191	$9,959 - $12,452 $830 - $1,037 $192 - $239	$12,453 - $14,940 $1,038 - $1,245 $240 - $287	$14,941 - AND ABOVE $1,246 $288	$0 - $13,820 - AND BELOW $0 - $1,152 $0 - $266
2	Annual $0 - $10,030 Monthly $0 - $835 Weekly $0 - $192	$10,031 - $11,033 $836 - $919 $193 - $212	$11,034 - $13,370 $920 - $1,114 $213 - $257	$13,371 - $16,720 $1,115 - $1,393 $258 - $321	$16,721 - $20,060 $1,394 - $1,671 $322 - $385	$20,061 - AND ABOVE $1,672 $386	$0 - $18,556 - AND BELOW $0 - $1,546 $0 - $357
3	Annual $0 - $12,590 Monthly $0 - $1,049 Weekly $0 - $242	$12,591 - $13,849 $1,050 - $1,154 $243 - $266	$13,850 - $16,782 $1,155 - $1,398 $267 - $322	$16,783 - $20,988 $1,399 - $1,749 $323 - $403	$20,989 - $25,180 $1,750 - $2,098 $404 - $484	$25,181 - AND ABOVE $2,099 $485	$0 - $23,292 - AND BELOW $0 - $1,941 $0 - $448
4	Annual $0 - $15,150 Monthly $0 - $1,262 Weekly $0 - $291	$15,151 - $16,665 $1,263 - $1,388 $292 - $320	$16,666 - $20,195 $1,389 - $1,682 $321 - $388	$20,196 - $25,255 $1,683 - $2,104 $389 - $485	$25,256 - $30,300 $2,105 - $2,525 $486 - $582	$30,301 - AND ABOVE $2,526 $583	$0 - $28,028 - AND BELOW $0 - $2,336 $0 - $539
5	Annual $0 - $17,710 Monthly $0 - $1,475 Weekly $0 - $340	$17,711 - $19,481 $1,476 - $1,623 $341 - $374	$19,482 - $23,607 $1,624 - $1,967 $375 - $453	$23,608 - $29,523 $1,968 - $2,460 $454 - $567	$29,524 - $35,420 $2,461 - $2,951 $568 - $681	$35,421 - AND ABOVE $2,952 $682	$0 - $32,764 - AND BELOW $0 - $2,730 $0 - $630
6	Annual $0 - $20,270 Monthly $0 - $1,689 Weekly $0 - $389	$20,271 - $22,297 $1,690 - $1,858 $390 - $428	$22,298 - $27,020 $1,859 - $2,251 $429 - $519	$27,021 - $33,790 $2,252 - $2,815 $520 - $649	$33,791 - $40,540 $2,816 - $3,378 $650 - $779	$40,541 - AND ABOVE $3,379 $780	$0 - $37,500 - AND BELOW $0 - $3,125 $0 - $721
7	Annual $0 - $22,830 Monthly $0 - $1,902 Weekly $0 - $439	$22,831 - $25,113 $1,903 - $2,092 $440 - $482	$25,114 - $30,432 $2,093 - $2,536 $483 - $585	$30,433 - $38,058 $2,537 - $3,171 $586 - $731	$38,059 - $45,660 $3,172 - $3,805 $732 - $878	$45,661 - AND ABOVE $3,806 $879	$0 - $42,236 - AND BELOW $0 - $3,520 $0 - $812
8	Annual $0 - $25,390 Monthly $0 - $2,115 Weekly $0 - $488	$25,391 - $27,929 $2,116 - $2,327 $489 - $537	$27,930 - $33,845 $2,328 - $2,820 $538 - $650	$33,846 - $42,325 $2,821 - $3,527 $651 - $813	$42,326 - $50,780 $3,528 - $4,231 $814 - $976	$50,781 - AND ABOVE $4,232 $977	$0 - $46,972 - AND BELOW $0 - $3,914 $0 - $903
9	Annual $0 - $27,950 Monthly $0 - $2,329 Weekly $0 - $537	$27,951 - $30,745 $2,330 - $2,562 $538 - $591	$30,746 - $37,257 $2,563 - $3,104 $592 - $716	$37,258 - $46,593 $3,105 - $3,882 $717 - $896	$46,594 - $55,900 $3,883 - $4,658 $897 - $1,075	$55,901 - AND ABOVE $4,659 $1,076	$0 - $51,708 - AND BELOW $0 - $4,309 $0 - $994
10	Annual $0 - $30,510 Monthly $0 - $2,542 Weekly $0 - $586	$30,511 - $33,561 $2,543 - $2,796 $587 - $645	$33,562 - $40,670 $2,797 - $3,389 $646 - $782	$40,671 - $50,860 $3,390 - $4,238 $783 - $978	$50,861 - $61,020 $4,239 - $5,085 $979 - $1,173	$61,021 - AND ABOVE $5,086 $1,174	$0 - $56,444 - AND BELOW $0 - $4,704 $0 - $1,085
Each Add'l Person	Annual $0 - $2,560 Monthly $0 - $213 Weekly $0 - $49	$2,561 - $2,816 $214 - $234 $50 - $54	$2,817 - $3,412 $235 - $284 $55 - $65	$3,413 - $4,268 $285 - $355 $66 - $82	$4,269 - $5,120 $356 - $426 $83 - $98	$5,121 $427 $99	$0 - $4,736 $0 - $395 $0 - $91

CHART95 CORRECTED JUNE 26, 1995

Appendix K

CHART 2
HEALTH DEPARTMENT INCOME LEVELS
FOR DETERMINING ELIGIBILITY FOR MEDICAL SERVICES
EFFECTIVE JULY 1, 1995, FOR NORTHERN VIRGINIA

No. IN FAMILY	INDIGENT PATIENTS		NEAR INDIGENT PATIENTS					INCOME LIMITS FOR WIC
	GROSS INCOME		GROSS INCOME	GROSS INCOME	GROSS INCOME	GROSS INCOME	GROSS INCOME	GROSS INCOME EFFECTIVE JULY 1, 1995
		LEVEL A - No Charge	LEVEL B - 10% Charge	LEVEL C - 25% Charge	LEVEL D - 50% Charge	LEVEL E - 75% Charge	LEVEL F - 100% Charge	BASED ON 185% OF POVERTY
1	Annual	$0 - $8,217	$8,218 - $9,958	$9,959 - $12,452	$12,453 - $14,940	$14,941 - $17,428	$17,429 - AND ABOVE	$0 - $13,820 - AND BELOW
	Monthly	$0 - $684	$685 - $829	$830 - $1,037	$1,038 - $1,245	$1,246 - $1,452	$1,453 -	$0 - $1,152
	Weekly	$0 - $158	$159 - $191	$192 - $239	$240 - $287	$288 - $335	$336	$0 - $266
2	Annual	$0 - $11,033	$11,034 - $13,370	$13,371 - $16,720	$16,721 - $20,060	$20,061 - $23,400	$23,401 - AND ABOVE	$0 - $18,566 - AND BELOW
	Monthly	$0 - $919	$920 - $1,114	$1,115 - $1,393	$1,394 - $1,671	$1,672 - $1,950	$1,951 -	$0 - $1,546
	Weekly	$0 - $212	$213 - $257	$258 - $321	$322 - $385	$386 - $450	$451	$0 - $357
3	Annual	$0 - $13,849	$13,850 - $16,782	$16,783 - $20,988	$20,989 - $25,180	$25,181 - $29,372	$29,373 - AND ABOVE	$0 - $23,292 - AND BELOW
	Monthly	$0 - $1,154	$1,155 - $1,398	$1,399 - $1,749	$1,750 - $2,098	$2,099 - $2,447	$2,448 -	$0 - $1,941
	Weekly	$0 - $266	$267 - $322	$323 - $403	$404 - $484	$485 - $564	$565	$0 - $448
4	Annual	$0 - $16,665	$16,666 - $20,195	$20,196 - $25,255	$25,256 - $30,300	$30,301 - $35,345	$35,346 - AND ABOVE	$0 - $28,028 - AND BELOW
	Monthly	$0 - $1,388	$1,389 - $1,682	$1,683 - $2,104	$2,105 - $2,525	$2,526 - $2,945	$2,946 -	$0 - $2,336
	Weekly	$0 - $320	$321 - $388	$389 - $485	$486 - $582	$583 - $679	$680	$0 - $539
5	Annual	$0 - $19,481	$19,482 - $23,607	$23,608 - $29,523	$29,524 - $35,420	$35,421 - $41,317	$41,318 - AND ABOVE	$0 - 32,764 - AND BELOW
	Monthly	$0 - $1,623	$1,624 - $1,967	$1,968 - $2,460	$2,461 - $2,951	$2,952 - $3,443	$3,444 -	$0 - $2,730
	Weekly	$0 - $374	$375 - $453	$454 - $567	$568 - $681	$682 - $794	$795	$0 - $630
6	Annual	$0 - $22,297	$22,298 - $27,020	$27,021 - $33,790	$33,791 - $40,540	$40,541 - $47,290	$47,291 - AND ABOVE	$0 - $37,500 - AND BELOW
	Monthly	$0 - $1,858	$1,859 - $2,251	$2,252 - $2,815	$2,816 - $3,378	$3,379 - $3,940	$3,941	$0 - $3,125
	Weekly	$0 - $428	$429 - $519	$520 - $649	$650 - $779	$780 - $909	$910	$0 - $721
7	Annual	$0 - $25,113	$25,114 - $30,432	$30,433 - $38,058	$38,059 - $45,660	$45,661 - $53,262	$53,263 - AND ABOVE	$0 - $42,236 - AND BELOW
	Monthly	$0 - $2,092	$2,093 - $2,536	$2,537 - $3,171	$3,172 - $3,805	$3,806 - $4,438	$4,439	$0 - $3,520
	Weekly	$0 - $482	$483 - $585	$586 - $731	$732 - $878	$879 - $1,024	$1,025	$0 - $812
8	Annual	$0 - $27,929	$27,930 - $33,845	$33,846 - $42,325	$42,326 - $50,780	$50,781 - $59,235	$59,236 - AND ABOVE	$0 - $46,972 - AND BELOW
	Monthly	$0 - $2,327	$2,328 - $2,820	$2,821 - $3,527	$3,528 - $4,231	$4,232 - $4,936	$4,937	$0 - $3,914
	Weekly	$0 - $537	$538 - $650	$651 - $813	$814 - $976	$977 - $1,139	$1,140	$0 - $903
9	Annual	$0 - $30,745	$30,746 - $37,257	$37,258 - $46,593	$46,594 - $55,900	$55,901 - $65,207	$65,208 - AND ABOVE	$0 - $51,708 - AND BELOW
	Monthly	$0 - $2,562	$2,563 - $3,104	$3,105 - $3,882	$3,883 - $4,658	$4,659 - $5,433	$5,434	$0 - $4,309
	Weekly	$0 - $591	$592 - $716	$717 - $896	$897 - $1,075	$1,076 - $1,253	$1,254	$0 - $994
10	Annual	$0 - $33,561	$33,562 - $40,670	$40,671 - $50,860	$50,861 - $61,020	$61,021 - $71,180	$71,181 - AND ABOVE	$0 - $56,444 - AND BELOW
	Monthly	$0 - $2,796	$2,797 - $3,389	$3,390 - $4,238	$4,239 - $5,085	$5,086 - $5,931	$5,932	$0 - $4,704
	Weekly	$0 - $645	$646 - $782	$783 - $978	$979 - $1,173	$1,174 - $1,368	$1,369	$0 - $1,085
Each Add'l Person	Annual	$0 - $2,816	$2,817 - $3,412	$3,413 - $4,268	$4,269 - $5,120	$5,121 - $5,972	$5,973	$0 - $4,736
	Monthly	$0 - $234	$235 - $284	$285 - $355	$356 - $426	$427 - $497	$498	$0 - $395
	Weekly	$0 - $54	$55 - $65	$66 - $82	$83 - $98	$99 - $114	$115	$0 - $91