NEW YORK STATE | Office of Mental Health

Rehabilitative and Tenancy Support (RTS) Services Planning and Documentation

DECEMBER 8, 2025

Housekeeping and Welcome

1. Please mute all lines
2. There will be a Q&A time at the end of the presentation
3. You will receive a copy of this presentation
4. This training is being recorded

SPA #20-0005

1. Approved for adoption November 1, 2020

2. Adds Housing Support Services under the Rehabilitative Services benefit

3. Permits the State to pursue Medicaid reimbursement for Rehabilitative and Tenancy Support Services (RTS)

Benefit

1. Implementation began January 2023
2. Eligible housing types- Supportive Housing, SP-SRO, CR-SRO. ESSHI units are not eligible currently.
3. Enhanced OMH State Aid contract funding
4. Reimbursement of LPHA recommendation assessment
5. No minimum frequency or service duration standards

Requirements

1. LPHA recommendation for services
2. Monthly reporting in the Child and Adult Integrated Reporting System (CAIRS)
3. Maintain service documentation in individual's chart
4. Agency is Medicaid enrolled provider

LPHA Recommendation

1. There is a standardized template that must be utilized to document eligibility for Rehabilitative and Tenancy Support Services.

2. The template can be found on the OMH website at: LPHA Rec Form

3. The recommendation form must be kept on file in the resident's housing record. There is no standardized assessment process or tool necessary to complete the recommendation; the recommendation is based on clinical discretion.

LPHA Recommendation

1. The LPHA should review any documentation that demonstrates whether the services could assist and individual in establishing or maintaining housing stability. These documents could include, but are not limited to psychiatric evaluation, psychosocial history, current residential service plan, progress notes, etc.

2. Note: this list is not intended to imply that a LPHA must review all these documents. Face-to-face or virtual assessment of the individual may also be used to determine medical necessity for these services.

Staffing Qualifications

1. New York State Department of Education Licensed Practitioner including:
   - -Licensed Master Social Workers (LMSWs)
   - -Licensed Clinical Social Workers (LCSWs)
   - -Licensed Mental Health Counselors (LMHCs)
   - -Registered Nurses (RNs)
   - -Licensed Practical Nurses (LPNs)
   - -Physician Assistants
   - -Nurse Practitioners (NPs)
   - -Medical Doctors (MDs and DOs)
   - -Licensed Psychologists or Psychiatrists

2. Unlicensed staff must be at least 18 years of age with a high school or equivalent diploma and may include those with a Master's in Social Work (MSW); bachelor's or master's degree in social work or other health or human services field or work experience in a health or human services field

Supervisory Staff

1. Must be licensed professionals or
   -Those with a Master's in Social Work (MSW)
   -Bachelor's or Master's degree in social work or other health or human services or
   -Individuals with a minimum of one year of experience providing direct services in medical, mental health, addiction, and/ or developmental disability programs

2. Supervisory arrangements are in accordance with scopes of practice established in the New York State Education Law

CAIRS

1. OMH expects providers to keep a current roster of enrolled individuals in CAIRS.

2. Providers are required to document completion of the LPHA recommendation for services in CAIRS and maintain the recommendation form in the housing record.

3. Providers will also be required to report service level data on a monthly basis indicating which Rehabilitative and Tenancy Support Services or other non-billable services were provided to residents. Up to four services per month.

4. Providers will be required to submit this information in CAIRS within 30 days after the end of the month in which services were provided.

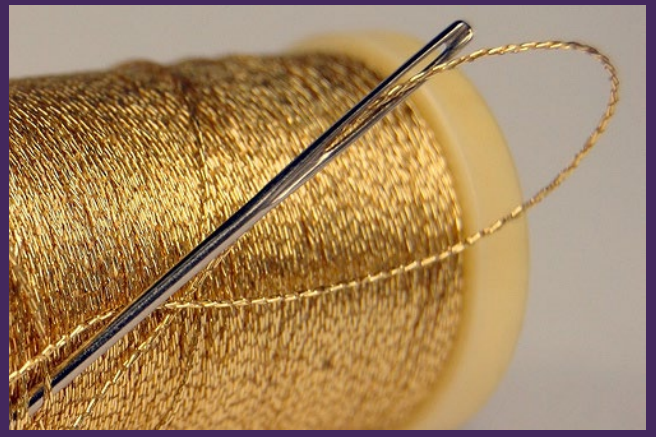
5. Referral information, support plans, progress notes, service plan reviews, etc., should be maintained in individuals' housing records/ charts. These are reviewed during a monitoring visit by NYSOMH.

Additional Guidance Documents Can Be Found on the OMH Website

1. Frequently Asked Questions (FAQ)
2. Supportive Housing Guidelines (Issues September 30, 2022)
3. State Plan Amendment (SPA) 20-05 Rehabilitative Housing Tenancy Supports

Supportive Housing Guidelines

The Golden Thread



What is the Golden Thread?

1. A narrative that is told through progress notes and support plans

2. Includes an individual's strengths, challenges, barriers, and interventions that assist the individual with remaining housed in permanent housing of their choice

Components of the Golden Thread

1. Admission Note- Identifies services to be completed before the service plan is written

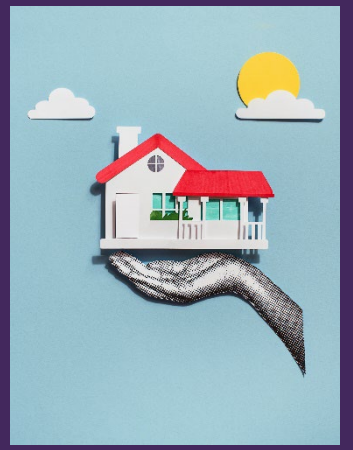
2. Assessment- Utilize assessments to identify areas of wanted or needed strengths, barriers, and interventions

3. ISP (Individualized Support Plan)- Use the information identified in assessments to create an ISP WITH the individual

4. Progress Notes- Document the individual's progress while following the ISP

5. Goal- Transition to and maintain permanent housing

Individualized Support Plan (ISP)



Creating a Good ISP

1. Collaborate
2. Be mindful of language
3. Set goals needed for discharge
4. List interventions
5. Determine the frequency
6. Revisit

Goals vs. Objectives

1. Goals are desired outcomes an individual wants to accomplish. Goals are generally broad, achievable and longer term.

2. Objectives describe the activities or measurable actions needed to achieve the overall goal and are generally shorter-term. Objectives provide a clear understanding of what tasks need to be done to move closer to achieving the goal.

Identifying SMART Goals

1. Use assessments to start a conversation

2. Ask yourself these questions before writing:
   -Specific: What does the individual want to work on?
   -Measurable: How will you know the individual has achieved the goal or objective?
   -Attainment: Is the individual able to realistically complete this?
   -Relevant: Does this align with the individual's interests, values, and areas of need that were identified in the assessments?
   -Time-based: What is the expected end date for the goal?

3. How can the goals and objectives be transformed into rts services?

Tips

1. Be specific and tailor the goal to what the individual wants to achieve

2. Goals that are not specific enough can cause confusion about what the individual is working towards

3. Goals should support recovery and ultimately discharge from transitional housing to more permanent housing

Language

1. Remember: This is a collaboration with the individual. Staff should not be telling the individual what goals they need to work on.

2. Language should be person-centered and non-stigmatizing.

3. Language should be easy for the individual to understand. Avoid words that are overly complex or clinical to avoid confusion.

4. Using an individual's quoted words is okay.

Objectives

1. Objectives are the steps that will be taken to meet each goal

2. Keep in mind an individual's strengths and barriers
   -How can strengths be used to achieve their goals?
   -What will act as a barrier?
   -How can staff assist?

Goal Example

1. Goal: Bob wants to regulate his mental health symptoms.
   -Bob and staff might be confused about how this goal will be addressed. Bob might also have other mental health symptoms he does or does not want to address right now.

2. Goal: “I want to stop having panic attacks.”
   -With a clearer goal, Bob and staff can better plan for how to manage his panic attacks.

Objective Example

1. Bob wants to stop having panic attacks. He is good at taking medication but struggles with remembering doctors' appointments and needs to find a new provider. What Objectives can Bob use?

2. Objective 1: With staff's help, I will look for therapists that accept my insurance.

3. Objective 2: With staff's help, I will call the provider together to make a new patient appointment.

4. Objective 3: With staff's help, I will fill in my new patient paperwork.

5. Objective 4: I will discuss with my therapist my panic attacks and how to make them stop.

6. Objective 5: I will practice the coping skills my therapist told me to use to make my panic attacks stop.

Interventions

1. Steps staff and the individual will take to meet the objectives.

2. For example: If Bob's first objective is, "With staff's help, I will look for therapists that accept my insurance," the interventions staff will do to assist the individual may read as such:

Intervention Example

Staff will meet with Bob weekly to conduct and internet search of treatment providers in his area. Staff will help Bob use the office computer to conduct a search on the internet. Staff will teach Bob how to conduct this search and assist him with inputting search criteria he identifies as important in locating a new provider. Staff will assist Bob with making a list of qualities he believes is important for the new provider to have. This list may include qualities such as gender, location, cost, availability, and type of therapy provided. Following the internet search, staff and Bob will develop a list of providers to contact and list questions Bob may have that he wants to ask. Staff will role play with Bob how to ask the questions he wants to ask. Staff will sit with Bob while he makes phone calls to inquire if the providers are accepting new patients, if they accept his insurance, and how to schedule a new patient appointment. Staff will prompt and remind Bob of anything he may forget during the phone call. Staff will take notes from the call and will compare these notes with Bob's understanding of what was said during each call. Following the calls, staff will talk and process with Bob how the phone calls went, and how to work through any concerns Bob may express. Staff will complete a cost-benefit analysis with Bob, helping him identify and list the pros and cons of choosing each of the providers contacted. Staff will review this analysis with Bob and encourage him to choose the best providers that can best meet his needs.

Frequency & Timeframe

1. Goals and/ or objectives should be measurable and flexible
2. Think of how often this goal will be worked on (daily, weekly, monthly…)
3. The frequency will be tailored to the individual and should be different for each goal
4. Goals/ objectives also have a specific timeframe

Example

1. Bob wants to stop having panic attacks. This goal could be set for 3 months from the day the plan is made. If needed, this date could be extended, or it could be completed sooner.

2. Searching for a therapist and making a new patient appointment might take a month from when the goal is set.

3. Working on his coping skills might be something that's worked on daily, weekly, or as needed.

Collaborate

1. Support plans should be a collaboration between all parties involved. This can include feedback from the individual, staff, friends, family, or other providers.

2. Utilize emails, phone calls, texting, case conferences, etc.

Measurable Actions

1. Think of how progress will be measured

Revisit

1. Develop an ISP within one month of resident move-in
2. Revisit ISP's every 3 months or as needed
3. Support plans are flexible and should be updated as needs change or goals are completed

Community Integration and Skill Building Skills

Community Integration and Skills Building Skills

1. Support for individuals who are transitioning into housing and integrating into their communities
    - -Needs assessment
    - -Community resource coordination
    - -Treatment planning
    - -Rehabilitative independent living skills training

Needs Assessment

1. Individualized assessment to identify strengths, preferences, and barriers to maintaining housing stability and integration
    -Informs Individualized Service Plan
    -Occurs at admission

Community Resource Coordination

1. Assistance to individuals with establishing a household, becoming oriented to the local community, and linking to services
    -Includes advocacy and linkage with resources when community tenure is threatened
    -For newly enrolled and established residents
    -Ex- Benefits advocacy; connecting with primary care

Treatment Planning

1. Individualized support planning
    -Identifies providers outside of the housing program
    -Occurs with newly enrolled residents

Rehabilitative Independent Living Skills Training

1. Coaching and skill-building services to support the resident to establish or maintain housing stability
    -For newly enrolled and established residents
    -Ex- Understanding rights and responsibilities as a tenant; developing a budget; learning how to access transportation, etc.

Stabilization Services

Stabilization Services

1. Services to support individuals already living in the community remain stably housed
    - -Tenancy support planning
    - -Rehabilitative independent living skills training
    - -Community resource coordination
    - -Crisis planning
    - -Crisis intervention

Tenancy Support Planning

1. Individualized support planning with individuals to review, update, and modify the existing support plan
    -Ongoing service with residents once they have become established
    -Ex- Service plan reviews

Rehabilitative Independent Living Skills Training

1. Coaching and skill-building services to support the resident to establish or maintain housing stability
    -For newly enrolled and established residents
    -Ex- Understanding right and responsibilities as a tenant; developing a budget; learning how to access transportation, etc.

Community Resource Coordination

1. Assistance to individuals with establishing a household, becoming oriented to the local community, and linking to services
    -Includes advocacy and linkage with resources when community tenure is threatened
    -For newly enrolled and established residents
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Crisis Planning

1. Support planning for individuals well before a crisis, or after a crisis has occurred

2. Help individuals and collaterals effectively recognize, manage, plan for, and prevent the escalation of symptoms or other factors so housing stability isn't jeopardized
    -Ex- Safety planning; linkage to primary care; crisis debrief

Crisis Intervention

1. Urgent and temporary support to individuals who are experiencing, or are at imminent risk or experiencing a crisis

2. These services aim to interrupt and/ or ameliorate acute distress and associated behaviors that threaten housing stability
    -Ex- Using de-escalation strategies; connecting with crisis resources (respite, ICSC, 988), etc.

Bob's Goal

1. Goal: "I want to stop having panic attacks."

2. Categories under Stabilization Services or Community Integration and Skill Building Services:
    -Community Resource Coordination
    -Treatment Planning
    -Crisis Planning
    -Crisis Intervention
    -Rehabilitative Independent Living Skills Training

Documentation

Important Factors

1. What are important things to keep in mind about documentation?
    -Timeliness
    -Accuracy
    -Comprehensiveness

Information to Include in Charts

1. Demographic information- Age, gender, race, benefits, insurance, address, phone number, social security number or non-citizens ID, etc.
2. All notes- Progress, admission, discharge, etc.
3. Intake and discharge plan
4. Diagnoses and support plans
5. Referrals
6. Care network and contact information- Providers, family, friends, emergency contacts, etc.

OMH Documentation Standards- Progress Notes

1. Date, type, mode, and place of contact
2. Duration of contact and service delivery
3. Describe the services delivered
4. Resident's response and progress pertaining to the ISP
5. Staff observations
6. Referrals and follow-up
7. Name, title, and signature of staff that provided the service(s)

Tips for Writing Good Notes

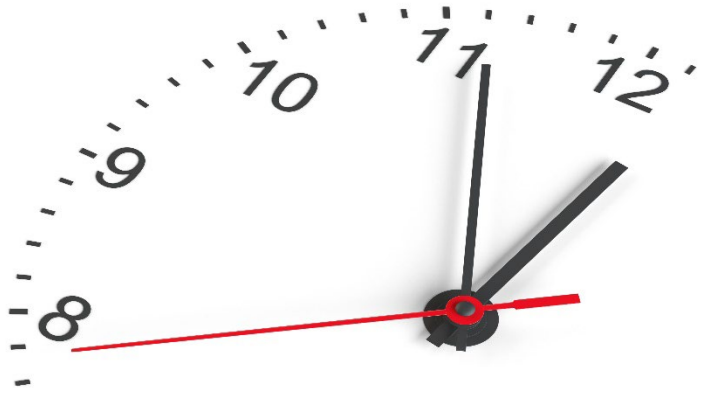
1. Be detailed. Not every detail needs to be included, but it needs to be detailed enough someone else could read it and understand what happened.

2. Include important information.
   -Safety/ health concerns, unaddressed needs, successes, challenges, etc.

3. If something needs to be done, conclude with an action statement.
   -”The writer will call Dr. Anderson to follow up with the insulin referral.”

4. Use objective language.
   -Don’t use “I,” “Me,” or “My.” Use language such as, “The writer observed…”
   -Using quotes from the staff or individual is okay as well.

Take a minute. Think about the 20th of last month. What did you wear? What did you eat? Who did you talk to? Did anything important happen?



Why Follow Best Practice Documentation Standards?

1. Memory isn't that reliable. If you rely on memory, how can you be sure details are correct?
   -With good notes you don't need a good memory.

2. Continuity of Care.
   -When information is relayed by word of mouth, it can be inaccurate or lost. What if the staff that knows the important information leaves the agency (planned or unplanned)? Now no one has the information. This can be detrimental to current staff and the individual's care.

3. Audits.
   -Do periodic internal audits. Don't wait until an audit to ensure charts are accurate.

If You Didn't Document It, It Didn't Happen

1. Even if an attempt was unsuccessful, document it anyway. Document all attempts to assist individuals with reaching their goals.

2. For example, if you attempted to engage an individual with an unplanned home visit and there was no answer at the door, document it. If you called the individual to discuss helping them schedule a doctor's appointment and they didn't answer, document it.

Note Example

Date: 11/01/2025

Duration: 30 minutes
Start: 9:15am End: 9:45am

Service: Tenancy Support Planning

The writer met with Bob at his apartment to develop an Individualized Support Plan (ISP). Writer and Bob reread the results of the Functional Assessment that was completed during a previous meeting on 10/15/2025. Writer and Bob talked about his goals of wanting to reduce the number of panic attacks he is having. Writer and Bob created a written list of challenges in Bob's life that make achieving this goal difficult at this time. Bob recounted needing to find a new therapist. Bob reports he is good at making calls and doesn't need assistance with scheduling appointments but could use assistance with locating a new therapist that accepts his insurance. Bob asked for staff assistance recording the appointments and setting reminders on his phone calendar and with completing paperwork needed for his doctor's appointments. Bob and the writer brainstormed ways staff could assist Bob in achieving his goals.

Betty Doe, Resident Counselor 11/1/2025

Support Plan Reviews

1. Individualized written support plans shall be reviewed at least once every three months, with the initial review occurring three months from the date of the admission. The review shall include participation of staff involved in the provision of services to the resident, the resident, and/ or if appropriate and with the approval of the resident, the resident's family or other collaterals. Such review should include the following:
    -The progress of the individual regarding mutually agreed upon goals and objectives in the individualized written service plan
    -Recommendations for adjustment of goals and objectives, time periods for achievement, intervention strategies or the initiation of discharge planning
    -Review of the individualized written service plan and signed by a staff person and the individual

Quick Review

Rehabilitative Support Services focus on intensive goal-orients interventions to address issues identified by and specific to an individual's needs.

Goals identified in a service plan focus on improving or maintaining individual skills that enable an individual to maintain permanent housing.

These services are approved through a Licensed Practitioner of Mental Health Recommendation.

Services are identified by type and written in an individualized strength-based person-centered service plan. This plan is written in collaboration with the individual and is reviewed and signed by a (QMHS) Qualified Mental Health Staff Person. Service plans are reviewed every 3 months or as needed.

Progress notes document the services provided. Notes must be detailed, signed, and dated.

FAQs

1. Can individuals that are not Medicaid eligible receive RTS?
2. How do I enter the new LPHA recommendation into CAIRS once the old one expired?
3. How does my agency enroll additional beds for RTS funding to an existing program?
4. Should non-billable contacts be included in CAIRS?
5. Does telehealth count as face-to-face?


Thank You!
What Questions Do You Have?