Emergency Relocations Toolkit

How Centers for Independent Living and other Community-Based Organizations can access emergency services funding through the Federal Emergency Management Agency (FEMA) for the federally declared COVID disaster.

Provided by the national SILVER Coalition

The national SILVER (Save Institutional Lives Via Emergency Relocations) Coalition – which includes experts in transitioning people with disabilities into the communities of their choice – has been advocating for the emergency relocation of residents from congregate facilities as one essential component of an emergency response platform.

Nothing in this document should be construed as legal advice. Anyone attempting to enter into agreements described in this document should consult qualified legal professionals.

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Introduction

The first concentrated outbreak of COVID-19 in the U.S. occurred in a Washington state nursing facility. That was in February of 2020. By March, 39 residents and staff at Life Care Center in Kirkland, WA, had died of the virus. It was a catastrophic event that focused the country on the emerging pandemic and the urgent need for such measures as social distancing, masking and vaccinations.

Early on, nursing facilities accounted for nearly half of COVID deaths nationally. As of June 2022, of the one million pandemic-related deaths in the U.S., almost a quarter (including residents and staff) are attributed to infections from long-term care facilities. Seen another way, about 10% of facility residents have died of COVID compared to 0.3% of U.S residents at large – a staggering 33-fold difference.[1] Currently, a

Very few conversations or efforts on emergency response utilize one of the disability community's central tenets – community integration.

1 The Centers for Medicare & Medicaid Service reports that, as of June 5, 2022, 153,201 residents of long-term care settings have died of COVID-19. Kaiser Family Foundation reports that 200,000 residents and staff in these facilities have died of COVID as of February 2022,

person is more than three times likely to be infected by COVID in a nursing facility than in the broader community.[2]

While most of the nation now considers COVID a more manageable pandemic, the ability to reduce risks of infection and death in institutions remains limited. A study found that the $9.4 billion in pandemic-related funds going directly to nursing facilities in 2020 had virtually no impact on COVID rates. (They did, however, appear to increase facility profit margins to five times pre-pandemic levels.)[3]

Campaigns to "harden" facilities against outbreaks may be somewhat beneficial but do not address the intractable failings of institutional care, which persistently raises health risk levels to well beyond those of community settings.

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concluding that: "nursing homes have continued to experience disproportionately high case and death rates in the country during the recent surge. Higher case rates may be attributed to the highly transmissible nature of Omicron and the nature of congregate care settings."

2 As of June, 2022, total COVID infections in nursing facilities is at 83% of their population size, while for the general public it is at 25% of population size.

3 Elizabeth Plummer, William Wempe, "Did performance-based nursing home payments meet their match with COVID?" (The Hill, 6/18/22)

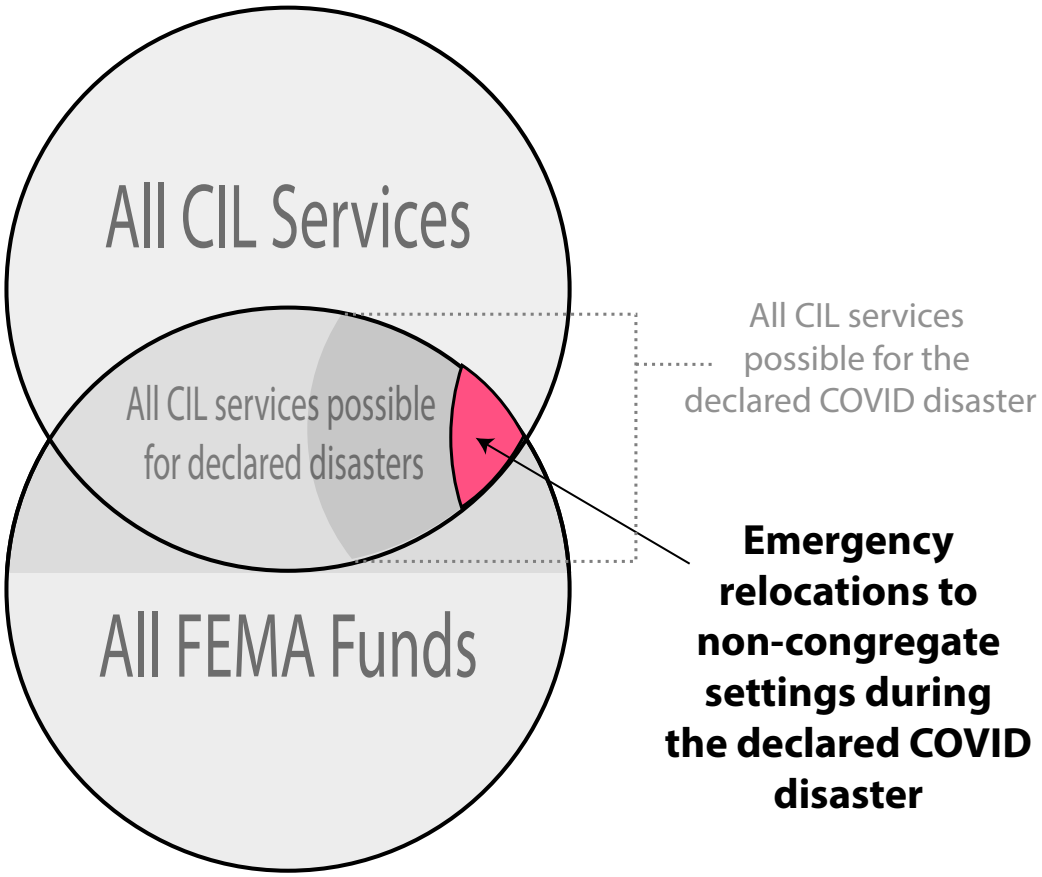
This is true especially during natural and human caused disasters, whether they be pandemics, hurricanes, floods or fires.

We cannot accurately estimate how many people who have died of COVID in an institution might have avoided infection in a non-congregate setting and thus survived, but data two years into the pandemic suggest the number is likely to be in the tens of thousands.

Despite the disastrous shortcomings of shelter-in-place strategies, very few conversations or efforts on emergency response prioritize disability civil rights laws or utilize one of the disability community's central tenets – community integration. The national SILVER Coalition's primary objective is to eliminate this oversight. This toolkit provides a roadmap for CILs and other community-based organizations (CBOs) to engage in emergency relocations during the declared COVID disaster and to seek FEMA reimbursements for their relocation work.

While SILVER and other advocacy groups seek to expand the participation of CILS and CBOs in disaster relief planning and execution, this toolkit restricts its focus to the specific area of emergency relocations from institutions to non-congregate settings during this declared COVID disaster. This small but significant inroad to providing equitable disaster supports to people with disabilities through

experienced and qualified providers from within the disability community should be considered the first of many much-needed advances by our nation's emergency response systems.



This toolkit focuses on emergency relocations from congregate settings to non-congregate settings during the federally declared COVID disaster.

Bases for CIL-coordinated Emergency Relocations

Long-term care residents in shared room during COVID pandemic.

The Supreme Court's Olmstead Decision mandates that people with disabilities have reasonable access to the residential settings of their choice. Under non-disaster circumstances states routinely rely on CILs to help fulfill this mandate by employing their competencies in disability-related supports. In 2016, a federal rule explicitly directing CILs to include transitions from institutions in their work further reinforces their central role in integrating and enfranchising people with disabilities. The Administration on Community Living rule states that CILS must:

> "Facilitate the transition of individuals with significant disabilities from nursing homes and other institutions to home and community-based residences, with the requisite supports and services."[4]

4 "Independent Living Services and Centers for Independent Living, A Rule by the Community Living Administra-

Early Successes in CIL-Coordinated Relocations

In 2020, transitions from long-term care facilities to community-based housing dropped precipitously as CILs and oversight agencies were forced to reduce services to institutionalized residents. States' shelter-in-place strategies typically compounded the pandemic's harms as residents suffered from severe isolation, under-staffing, over-crowding and reductions in care and regulatory oversight.

Far from complacent, facility residents protested in several states, and anecdotal accounts from one state administrator indicated a spike in self-directed evacuations, a move that put the evacuees' essential supports and services in grave jeopardy. These actions sent a strong message to the world that shelter-in-place strategies for congregate care settings were, at best, marginally effective while deeply oppressive.

In response, CILs in at least three states[5] undertook to provide facility residents with lifesaving and life-sustaining emergency relocation services. After coordinating

tion on 10/27/2016"

5 The SILVER Coalition has identified three CILs – in Colorado, Illinois, and Pennsylvania – that undertook emergency relocations from long-term care facilities. It is possible there are more.

attendant supports and supplies for daily living needs, the CILs prepared expeditious transitions of residents to safer temporary non-congregate housing. CARES Act dollars supported some of this work, but the CILs found few additional funding sources to establish their relocation work at a significant scale. Despite early skepticism from the larger disability community, these programs successfully relocated a handful of individuals in the past two years, most of whom then moved to permanent independent living arrangements.

In June of 2020, FEMA announced that they would be providing reimbursement under Public Assistance, Category B Emergency Protective Measures to states that opted to move unhoused people to non-congregate sheltering. One of the three CILs conducting emergency relocations, Roads to Freedom Center for Independent Living (RTFCIL) in Pennsylvania, petitioned FEMA for support, claiming that occupants of institutions were essentially unhoused, living under similar conditions as those residing in homeless shelters. Unfortunately, FEMA provided no clear guidance to its regional, state and local offices for utilizing CILs during disasters. As a result, RTFCIL received contradictory responses from various government agencies, which dangerously delayed RTFCIL's relocation work and prevented coordination with other Pennsylvania CILs that were prepared to participate.

Shortly after FEMA's announcement, the agency published an addendum in July (excerpted in Appendix A) that explicitly names CILs as an eligible provider for personal assistant services during declared disasters. Since its publication, RTFCIL has successfully applied for reimbursements for portions of its relocation work and anticipates further reimbursements for related activities during the federally declared COVID disaster. RTFCIL, as a SILVER affiliate, has since become a national advocate for centering CILs in emergency relocation work.

Nursing home resident protesting inside locked facility during COVID pandemic.

Case Study: Jason

Jason is a 38-year-old man from Pennsylvania. He had been left by his previous facility at an emergency room in Lycoming County. The hospital transferred him to its in-patient behavioral health unit while seeking a more permanent residential setting. During this time, a surgery to remove a brain tumor left him completely blind and hard of hearing.

The hospital struggled to find Jason residential placement, as nursing facilities, group homes, personal care homes, and other settings all rejected his application due to a mental health diagnosis and complex medical issues. As COVID outbreaks repeatedly threatened Jason's unit, staff at Roads to Freedom Center for Independent Living contacted the hospital to propose an emergency relocation. Jason embraced the proposal. He was not fully vaccinated and feared that his recent brain surgery put him at further risk of infection.

RTFCIL contacted a local hotel owner to arrange for an accessible room and advised him that Jason's stay would be upwards of 90 days because he lacked all documentation needed to apply for permanent housing. Jason had very few clothes, so RTFCIL took on the additional task of stocking his daily living supplies. Prior to his relocation and essential for a safe transition, RTFCIL set up an intake

meeting between Jason and a live-in caregiver agency. Within two weeks the hospital had completed a consultation with an outpatient psychiatrist and established his outpatient care plan.

After preparing the hotel room, which was a two-bedroom suite, RTFCIL transported Jason to his temporary accommodations and oriented him with his new live-in caregiver. While Jason stayed at the hotel, RTFCIL organized his disability services, a primary care provider, orthopedic physicians, the process for obtaining waiver services, and acquired his much-needed vital records. They also purchased him clothing and hearing aids. Due to Jason's homeless status he was bumped up on the housing list and successfully moved into his new apartment in May of 2022.

See an interview with Jason here:
shorturl.at/dhvxy

Jason arriving at his hotel suite.

Roads to Freedom's FEMA-funded Relocations

As of July 2022, Roads to Freedom Center for Independent Living has relocated three persons from institutions using FEMA funding. The costs for Jason's 63-day hotel stay including supports and services for 90 days averaged $474 per day. FEMA reimbursed $42,666 of Jason's relocation costs, and the assigned managed care organization (MCO) paid $6,859 for additional attendant services. "John F," who was relocated directly to permanent housing, received 59 FEMA-funded hours of emergency attendant care before fully transitioning to MCO-supported home and community-based services. "Jeff F" spent 15 days in a hotel with full supports, averaging $212 per day, before transitioning to a permanent community-based setting. FEMA reimbursed $3,189 for Jeff's relocation out of a total $4,084. (The remainder was covered by the MCO).

Interview: Anaya Robinson

Anaya Robinson was Assistant Director of Atlantis Community, a Denver-based CIL that has developed an emergency relocation program, which includes diversions from institutions and partnerships for workforce development.

Take us back to the beginning of the pandemic. What was that like for you in your capacity to transition people from congregate settings?

Our Medicaid transition program in Colorado got immensely harder to navigate and implement because we weren't allowed to go into nursing facilities. So we tried to get facility residents pieces of technology that they would need to be able to work with us virtually and then trained them on the go. It really broadened our scope to add in a diversion element to our work, too, because we were seeing so many folks who were unhoused, especially from our community, being put into giant congregate

shelters that the city had used FEMA funds to create. In reality, they were just more congregate settings that increased the risk of contracting COVID.

We also looked at the gaps within our Medicaid transition program, which supported transitions only from nursing facilities, and we understood our community was being significantly impacted within all sorts of congregate settings. So we created a pilot to open up access to transitions out of congregate settings as a whole, as opposed to just the institutions that our Medicaid program recognized.

Did your transitions drop at the beginning of the pandemic or were you able to keep your levels at the pre-pandemic rate?

Our Medicaid transition numbers definitely decreased a bit, but our transition numbers as a whole, with the inclusion of the pilot, actually increased slightly in 2020 and '21. I believe prior to the pilot we averaged about two to four people a year, and with the pilot six or seven a year.

How were the transitions in the pilot program different from regular transitions?

One of the components that was significantly different was moving people out of congregate settings immediately into hotel rooms. We then went through the tran-

sition process while they were in the hotel as opposed to while in the congregate setting. We moved folks into hotel rooms first and foremost to help them quarantine with social distancing, because that wasn't an option where they had previously been, and we got them regular testing to make sure that they hadn't contracted COVID before they left the facility. We got their services set up, connected them to housing vouchers and then ultimately to an apartment.

What were the shortest and longest hotel stays in the pilot program?

We actually had one individual who never went into the hotel, who went directly from his assisted living to an apartment because his voucher came through quickly. Otherwise, I think the shortest was three weeks. The longest was three months. But we had kind of a soft mandatory 14-day requirement as a quarantine period so that we could ensure testing and make sure that we weren't moving somebody out of the quarantine space into the community if they had contracted COVID in the facility. Folks got tested a few times a week for those first 14 days before we decided they were in the clear to leave the hotel.

Can you describe the standard set up you had in the hotels?

So essentially everybody got their own rooms. So they would be in the same hotel, but in separate rooms to make sure that they could maintain that distance outside of providing services, that they could quarantine as much as possible, but still be in the same building. So they were able to go to the hotel lobby and have conversations. And that's kind of one of the ways we tried to combat isolation, as well, by making sure that all of the folks were in the same area but had their own space. And generally the hotel was able to put the rooms fairly close together.

What were some of the things early on that you had to adjust for?

A big obstacle was getting access to folks in congregate settings because you weren't allowed to enter facilities unless you were staying there or worked for one of the organizations that was contracted to run them. Then figuring out how to get services into the hotel immediately, because – I know this is a fairly common problem across the country – there's usually a delay between moving somebody out of a congregate space into the community and engaging home and community-based services.

To address that, we partnered with another organization that provides services to folks who are unhoused.

They helped on the employment side to find individuals to work as attendants for people who we were transitioning, with the hopes that those folks would then be able to live in the hotel at the same time while being trained on providing services. These were paid positions so that by the time the folks who were transitioning left the hotel, the trained attendants would hopefully have saved enough money to get themselves housed as well. So filling that gap was an issue from the beginning.

Also we had to find hotels that were willing to partner with us and provide a discounted rate as we were using CARES Act dollars to pay for this program. So while we had a decent amount of money, it was time limited and capped. That took a lot of negotiations with hospitality companies to get rates that made it sustainable.

And we did a lot of figuring out on how to support individuals once they were in the hotel rooms to decrease isolation. It's often hard to move from a congregate setting into your own space and deal with the effects of isolation, and when you layer a pandemic on top of it and the necessity to socially distance, it just significantly increases those effects.

How did you resolve the barrier of access to institutions during that time?

We utilized some of the relationships that we have and built new ones. So talking to a lot of service providers and engaging with the ombudsman programs for the nursing and assisted living facilities, and working with community members who knew folks who were in congregate settings. We also worked pretty heavily with the shelter provider system to get them information about the pilot and to help us identify folks in need.

It was a really intentional community effort of building and maintaining relationships to make sure the folks who needed help got the information and knew how to contact us.

Would you say that the Ombudsman program was a key player at that point?

Yeah, I think our local ombudsman office was really helpful in making sure that people knew that this option existed. And I think just general contacts with a lot of the hospital systems, too, and some of the rehab hospitals to make sure that they knew that if they had folks that were likely get discharged to nursing facilities to call us first.

Did the P&A have any role in the pilot's success?

The state ombudsman is housed in our P&A in Colorado, so there wasn't a whole lot of need for the P&A to be involved in most cases.

What's your success rate? What's your full transition rate?

I believe there were only two folks in the pilot who didn't end up in permanent housing. So I think we're at 13 individuals total who have either transitioned out of an institution or been diverted from an institution into permanent housing and also caregivers who were or able to get permanent housing of their own through the process.

Did anyone contract COVID during the relocation process?

We didn't have anyone get COVID. We did have a few folks who still had symptoms from a previous COVID contraction from before they transitioned out.

So is there a general takeaway you have about what's key to a successful relocation, what you feel is important for people to know?

Yeah, I think relationships and partnerships, especially during a pandemic. One of the reasons that we were able to implement this program so quickly and I think so well

is our relationships with state partners and being able to gain some flexibility from our state Medicaid office in expediting eligibility and funding for housing vouchers. For instance, one of the largest congregate shelters that expanded with FEMA dollars closed right before Christmas. All of the individuals living there were displaced to motel rooms or other shelters or back to the street. So we worked with our Division of Housing to secure 20 vouchers for some of those individuals.

I also think one of the biggest barriers nationally to transitioning people out of institutions is that there're just not enough people willing to do the job to provide the necessary services for my community. So really figuring out inventive and flexible ways to fill that workforce gap and really tapping into the options that no one else is thinking about is key.

"It's important to advocate for ways to build different funding streams that will pay for temporary housing, whether it's a hotel or a transitional apartment or some other non-congregate setting as opposed to a nursing facility."

When we think about the number of unhoused folks in this country who want to be working, we can take care of that workforce issue pretty quickly. We need to be flexible and willing to work with people, to support them through training and developing their independent living skills that come with shifting from not having worked for

a really long time to working again and organizing daily routines to maintain it.

We're also working with folks at risk of institutionalization to make sure that they get those vouchers and we support them inside their apartments, getting them set up with services. The pilot kind of shifted in this way when things started opening up.

What would you say have been the biggest barriers to expanding your pilot program?

I think the CARES Act dollars and some of the other stimulus package dollars that we were able to get helped us to be a little more flexible during the pandemic. But we don't necessarily have a funding stream to pay for a lot of the things that come with transitions. I mean, we're a fairly small nonprofit that was stretched pretty thin during the pandemic. Our regular funding streams actually decreased during the pandemic.

We also had to maintain core services, as we're regulated to do. So we increased the workload without increasing staff. And that's sort of a symptom of not having a funding stream that's going to be consistent. You can't hire someone knowing that you're going to have to fire them when the situation changes. So I guess some people would say, "wow, hotels, that sounds really pricey for doing this kind of work – pricey and risky."

What's your reponse to that?

In the overall scheme of things the government is essentially paying for the transition no matter what process you choose. It's a funding stream shift that puts somebody in temporary housing or in a hotel during that transition period to keep them safer and to help them access their right to live in the community more quickly. It's not necessarily more expensive than them staying in an institution. So it's important to advocate for ways to build different funding streams that will pay for temporary housing, whether it's a hotel or a transitional apartment or some other non-congregate setting as opposed to a nursing facility.

You used CARES Act funds for your pilot program. Why didn't you apply for FEMA funding?

Part of the reason was that we would have had some 30 contracts across the seven counties we serve because FEMA allocates these funds through county EMAs. I think it might be a little easier in the future. But also, in the beginning of the pandemic, the city and county of Denver told us that they had already contracted with the shelter providers and that was all of the capacity they were willing to deal with regarding FEMA funds.

I think in the future it's definitely something that we will look at. In the grand scheme of things, CILs have an ob-

ligation to provide transition and diversion services and whether it's through FEMA dollars or not, if that need exists during an emergency or a disaster, we still have an obligation to figure out how to provide those services.

Atlantis Community Pilot Program Partners

To build its relocation pilot program Atlantis Community partnered with a coalition for the unhoused, disability services providers and advocacy groups, and city and state agencies.

- The Reciprocity Collective
- Colorado Cross Disability Coalition
- Rocky Mountain Human Services
- Front Range Home Care Services
- 5280 Home Care & Attendant Services, Inc.
- Division of Housing
- City and County of Denver
- Department of Health Care Policy and Financing
- Department of Public Health and Environment

Questions about FEMA

What is FEMA?

FEMA is the U.S. government's lead agency for anticipating and responding to declared disasters. It collaborates with other entities, such as the Red Cross and the National Guard, and provides funding to regional, state, local and tribal emergency response agencies to address disasters in their jurisdictions. Those agencies, in turn, are empowered to provide funds to other entities that qualify under FEMA guidelines.

When will FEMA fund a program?

FEMA and its area agencies will provide funds during declared disasters or for disaster preparedness work. As described by FEMA, "the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5207 (the Stafford Act) §401 states in part that: 'All requests for a declaration by the President that a major disaster exists shall be made by the Governor of the affected State.'" U.S. territories and tribes may also request a Presidential declaration. Disasters can be acts of nature, person-made, or acts of terrorism. The COVID pandemic, for instance, has been declared a federal disaster in every state. Up through

November 2021, FEMA had spent $32.1 billion in COVID-19 assistance.

What does FEMA fund?

FEMA funds a broad range of disaster-related programs, which may include temporary housing, housing replacement, medical assistance, search and rescue, funeral expenses, and pre-disaster mitigation activities. FEMA often provides reimbursement (not upfront funding) through its state and county emergency agencies as well as so-called "eligible non-profits." FEMA routinely funds emergency relocations, such as those described above.

For more answers to FEMA-related questions, please email: Marcie Roth marcie@wid.org

Questions about Reimbursements

Who is eligible to apply?

Under the emerging policy, CILs and similar consumer-led local agencies have been reimbursed. FEMA now considers CILs to be "Community Based Organizations" in their 2020 addendum (See Appendix A), all of which are eligible for funding. It is still not established, however, that CILs will be recognized as private nonprofits in order to request reimbursement directly from FEMA the same way institutional settings, sheltered workshops and adult day care for people with disabilities can. Currently CILs have received reimbursements strictly from local emergency management agencies.

My organization serves people with disabilities in several counties. Can I apply to my state's EMA directly for reimbursement or will I have to apply in each county that we relocate someone?

Currently, as an eligible nonprofit, organizations such as CILs must go through each county emergency management agency in which they are providing services. SILVER affiliates continue to seek improvements in the efficiency of flow-through funds and hopes FEMA will one day provide

opportunities for organizations with broader service areas to apply directly to state EMAs.

What happens to our reimbursement eligibility if we start emergency relocation processes during a declared disaster but haven't finished before the disaster declaration ends?

Reimbursement is only available for the period of the declared disaster.

What activities and costs are eligible for reimbursement?

Emergency protective measures conducted before, during, and after an incident are eligible if the measures:

1) eliminate or lessen immediate threats to lives, public health, or safety, or
2) eliminate or lessen immediate threats of significant additional damage to improved public or private property in a cost-effective manner.

Eligible emergency protective measures and costs that have been reimbursed include:

- Transporting and pre-positioning equipment and other resources
- Supplies and commodities
- Medical care and transport
- Evacuation and sheltering
- Use or lease of temporary generators for facilities that provide essential community services
- Dissemination of information to the public to provide warnings and guidance about health and safety.

All requests must be for $3,300 or more. You may bundle smaller cost items to meet this minimum threshold.

How do we apply for reimbursement?

To reimburse the costs for emergency relocations or other transition supports, find your county emergency management agency (County EMA). You may find your County EMA on state government websites (See Appendix C for links). Submit a memorandum of understanding (MOU) that may be modeled after the interactive sample in Appendix D.

An MOU is a broad understanding between the EMA and the potential fund recipient. You should include in the MOU a description of all the services and supports your organization is capable of providing under a declared disaster even if you have no intention of using all of them. Your MOU must be signed by the appropriate authorities from the County EMA. After finalizing this agreement, you may submit invoices for each service cost with supporting documentation.

The EMA may ask you to provide information on your reimbursement request for the following. Appendix E is an interactive form with these request areas.

- The number of non-congregate shelterees
- Their age groups 0-2, 3-6, 7-12, 13-17, 18-21, 22-65, and 66+
- Types of disabilities or access and functional needs

- Number of household pets, and assistance and service animals sheltered and the type of shelter provided (e.g., stand alone, co-located, or co-habitational)
- Length of temporary housing per "household unit"
- Number of meals and other services provided

This information can be provided in narrative, spreadsheet, or other format (such as Appendix E). The County EMA directs the request to State EMA and passes the funding requests to FEMA.

The MOU can be modified for your program and county. We recommend that you cc your Regional and State EMAs, as well as FEMA Officers. Additionally, you may send the MOU to the Partnership for Inclusive Disaster Strategies, which will keep track of applications.

For more answers to reimbursement-related questions, please email: Misty Dion mdion@cilncp.org

Questions about Emergency Relocations

What is "emergency relocation" as opposed to "transition?"

RTFCIL describes emergency relocations as "transitions on steroids," in which the typically long wait for housing is bypassed through interim accommodations. The CIL organizes all the support needs that are required for standard transitions but temporarily relocates residents of congregate care settings to temporary housing, such as hotels or short-term apartments. Residents leaving high-risk, high-density settings are provided social distancing and appropriate direct care during their interim placement. Meanwhile, the CIL attempts to arrange permanent non-congregate housing and related supports and services.

What counts as temporary emergency housing eligible for FEMA reimbursement?

FEMA, through state, local, and county emergency agencies, may reimburse eligible government and non-government providers for costs of temporary shelter or housing during disasters, under Public Assistance. (Individual housing assistance is a very different program, and generally only available to owners and renters of homes in disaster impacted communities.) FEMA has covered the costs of

hotel rooms for people seeking to get out of nursing homes experiencing COVID outbreaks. The duration of temporary housing can vary based on the circumstances of the disaster and the availability of permanent accommodations. CILs that have relocated long-term care residents during COVID have made temporary placements lasting between two weeks and three months.

Won't relocations take funding, housing, and human resources away from home and community based services (HCBS) programs?

People in congregate care settings who request community-based housing and services typically wait several months to over a year for their transition. Hundreds of people on transition lists have died in facilities while waiting for HCBS housing and services. The expectation is that many of the people who relocate will eventually transition permanently. HCBS and emergency relocations, even when housing and other benefits are included, cost less than keeping people in institutions, so there are universal savings in both programs. During the relocation period, Medicaid payments shift to safer and typically lower-cost services and supports. Relocations save Medicaid dollars and support local businesses, such as hotels, food services, and the home care attendant workforce, providing jobs for hard-hit communities.

Why isn't my state funding relocations from congregate care facilities?

Allocations of federal emergency funds for pandemic relief have been left up to governors. Many states, if not all, provided increased payments to nursing facilities to attempt to control COVID outbreaks through shelter-in-place strategies rather than shifting funding to emergency relocation programs.

How would you be able to take care of people in a setting that has no durable medical equipment, no support staff?

During natural disasters, it is standard practice to identify settings capable of providing shelter for evacuees and displaced persons and then preparing those settings with necessary healthcare and daily living supports. In emergency relocations CILs identify safe accessible temporary settings first, then coordinate and obtain medical equipment, arrange for support staff, food, and transportation. These are the same services CILs organize for traditional transitions to permanent settings. Experienced staff can accomplish many of these preparations within days of identifying a consumer. The most significant bottleneck to permanent transitions - and why many such transitions can take months or years - is in obtaining permanent housing; this bottleneck is virtually

eliminated in emergency transitions, in which the housing stock expands to temporary locations, such as hotels and university housing.

Why would a hotel be any safer than a nursing home?

Facility spread is much less likely in a setting where residents are provided single-occupancy rooms and more individualized support. Many facilities house up to four residents per room, which makes social distancing impossible, and utilize a one-to-many staff system, which promotes the spread of infections. Facilities commonly implement a variety of other institutional policies that increase risks to residents, such as communal dining, shared phone privileges and group smoke breaks.

There is a shortage of housing. What makes you think hotels or other places will provide housing?

During the pandemic, settings such as hotels suffered downturns in business. CILs doing this work found that hotels were eager to provide temporary housing. Relocation programs reimburse hotels at a competitive rate.

How can I physically move fragile people out of institutions?

The same way people are transitioned normally. Most CILs are experienced in using medical transport, commercial transport and other accessible vehicles as needed. Residents on home and community based services (HCBS) waivers can utilize non-medical transportation as well.

How am I going to ensure the safety of people with cognitive issues, such as Alzheimer or psycho-social disabilities?

Live-in caregivers or family members are an option to ensure the safety of individuals with cognitive or psycho-social disabilities. Emergency relocations should not occur without ensuring proper services and supports. In fact, emergency relocation plans should significantly reduce the dangerous ad hoc, disorganized evacuations of facilities that have occurred across the country during the pandemic.

For more answers to relocation-related questions, please email: Anaya Robinson anaya@transformativefreedomfund.org or Misty Dion mdion@cilncp.org

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Appendix A: FEMA addendum

FEMA

From "Personal Assistance Services Addendum to the Mass Care/Emergency Assistance Pandemic Planning Considerations Guide," pp 7-8.

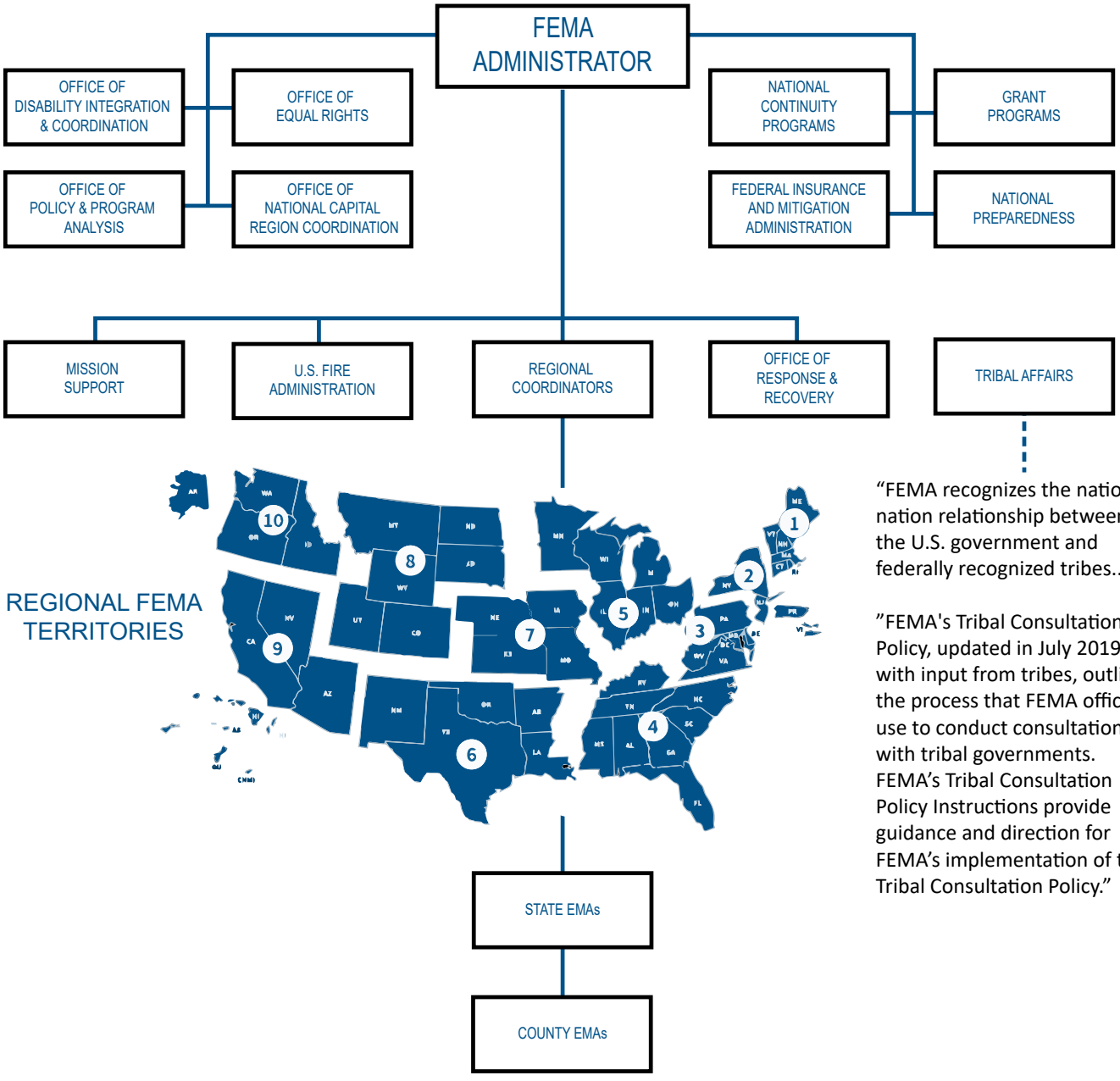
Establishing Relationships with Community-Based Organizations

Long before an emergency or disaster occurs, SLTT [state, local, tribal and territorial] emergency managers and shelter planners must work closely with individuals in the community who require PAS [personal assistance services] to understand their perspective on the proper care needed. To ensure individuals with disabilities maintain their independence and are not placed into institutional settings during an emergency, emergency managers and shelter planners are responsible for establishing relationships with community-based organizations (CBOs) who routinely advise on or deliver PAS to children and adults with disabilities. Provided below is a list of recommended

CBOs providing or advising on PAS:

- Centers for Independent Living
- Home health agencies
- Respite providers
- Mental health organizations
- Developmental disability organizations
- Aging organizations, such as Area Agencies on Aging
- Advocacy groups
- Protection and advocacy agencies
- Medical or Vocational service agencies
- Faith-based organizations, local houses of worship, and voluntary agencies
- American Red Cross chapters

Appendix B: Partial FEMA organizational chart



"FEMA recognizes the nation to nation relationship between the U.S. government and federally recognized tribes....

"FEMA's Tribal Consultation Policy, updated in July 2019 with input from tribes, outlines the process that FEMA officials use to conduct consultation with tribal governments. FEMA's Tribal Consultation Policy Instructions provide guidance and direction for FEMA's implementation of the Tribal Consultation Policy."

Appendix C: FEMA regional & state contacts

Region 1

Connecticut*, *Maine*, *Massachusetts*, *New Hampshire*, *Rhode Island*, *Vermont

877-336-2734 fema-r1-info@fema.dhs.gov

Tribal Affairs
fema-R1-Tribal@fema.dhs.gov

Region 2

New Jersey*, *New York*, *Puerto Rico*, *Virgin Islands

FEMA-R2-ExternalAffairs@fema.dhs.gov

Region 3

Delaware*, *Maryland*, *Pennsylvania*, *Virginia*, *District of Columbia*, *West Virginia

215-931-5500

Tribal Affairs
FEMA-R3-Tribal@fema.dhs.gov

Region 4

Alabama*, *Florida*, *Georgia*, *Kentucky*, *Mississippi*, *North Carolina*, *South Carolina*, *Tennessee

770-220-5200 FEMA-R4-Info@fema.dhs.gov

Tribal Affairs
202-679-8117 Karlene.Jessie@fema.dhs.gov

Region 5

Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

312-408-5500 fema-r5-info@fema.dhs.govFe-ma-r5-info@fema.dhs.gov

Tribal Affairs
312-408-5286 fema-r5-tribal@fema.dhs.gov

Region 6

Arkansas, Louisiana, New Mexico, Oklahoma, Texas

940-898-5399

Tribal Affairs
202-258-1485 FEMA-R6-Tribal-Affairs@fema.dhs.gov

Region 7

Iowa, Kansas, Missouri, Nebraska

816-283-7061 FEMARegion7info@fema.dhs.gov

Tribal Affairs
202-256-5856 sara.henry@fema.dhs.gov

Region 8

Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

303-235-4800

Tribal Affairs
CO, MT, UT, WY: Carol.Garcia@fema.dhs.gov
ND, SD: Cathy.Bachhuber@fema.dhs.gov

Region 9

Arizona, California, Hawaii, Nevada, Guam, American Samoa, Commonwealth of Northern Mariana Islands, Republic of Marshall Islands, Federated States of Micronesia

510-627-7100

Tribal Affairs
202-341-2821 pamela.joe@fema.dhs.gov

Region 10

Alaska, Idaho, Oregon, Washington

425-487-4600 FEMA-R10-Info@fema.dhs.gov

Tribal Affairs
FEMA-R10-Tribal@fema.dhs.gov

Appendix D: Sample Memorandum of Understanding

MEMORANDUM OF AGREEMENT BETWEEN

_____

AND

_____

THIS AGREEMENT, entered into as of this day of _____by and between

_____, with a principal place of business at

_____;
hereinafter called the “County” and

_____, a non-profit organization, with a principal place of business at

_____
hereinafter called the “Contractor.”

WITNESSETH THAT: WHEREAS, the State of _____is under Emergency Declaration for COVID-19 pandemic;

WHEREAS, Federal Emergency Management Agency (“FEMA”) has provisions for non- congregate

sheltering of “at-risk persons” in congregate settings through Public Assistance Category B Non-Congregate Shelter, hereafter called FEMA Category B[1];

WHEREAS, persons with a disability or who are elderly at Long-Term Care Facilities are a vulnerable “at-risk” population residing in congregate settings, hereto referred to as “vulnerable congregate residents;”

WHEREAS, FEMA provides guidance to State, Local, Tribal and Territorial (“SLTT”) partners to anticipate and attend to the needs of people with disabilities;

WHEREAS, FEMA encourages SLTT partners to plan for Personal Assistance Services (“PAS”) prior to disasters;

WHEREAS, FEMA identifies Centers for Independent Living (“CILs”) as a valuable resource for at-risk congregate residents and highlight the critical role of CILs in providing reasonable disability modifications and accommodations as needed for safe and expeditious services including, but not

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1 FEMA-Public Assistance Policy Guide, Version 4, July 2020, Emergency Protective Measures Category B, 0.2

limited to, transportation, food, shelter, durable medical equipment, effective communication access, health maintenance end personal assistance services (PAS) for residents in non-traditional settings[2];

WHEREAS, FEMA requires that the "responsible entity" for submitting and receiving FEMA Public Assistance Funds must be a SLTT partner and FEMA allows the SLTT partner to serve as a pass-through for costs incurred by private non-profit agencies providing needed services;

WHEREAS, FEMA requires the SLTT partner formalize an agreement with the private non-profit PAS provider for whom the SLTT will submit that agency's requests for FEMA Category B reimbursement[3];

WHEREAS, CONTRACTOR is a CIL and a provider with a proven track record and resources to provide PAS in non-congregate and non-traditional settings for vulnerable congregate populations;

WHEREAS, COUNTY is a SLTT seeking a provider

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2 PEMA-Addendum to the Mass Care/Emergency Assistance Pandemic Planning Considerations: 12/720. pg.4

3 Ibid, pg 2. B. 1.b.

to assist with providing PAS prior to and during disasters in COUNTY;

WHEREAS, CONTRACTOR has approached COUNTY as a provider willing to submit through FEMA's established processes, requests for reimbursement on behalf of COUNTY for FEMA Category B assistance reimbursement;

WHEREAS, under FEMA Category B program, COUNTY would function as a pass-through entity with no financial obligation or responsibility of outcome to the PAS administered through the CONTRACTOR;

WHEREAS, CONTRACTOR is obligated to fully and completely comply with all requirements and obligations of the FEMA Category B program;

WHEREAS, CONTRACTOR is responsible to provide COUNTY with such documentation as is reasonably necessary to assure COUNTY that CONTRACTOR is properly disbursing and administering FEMA Category B program funds; and,

WHEREAS, CONTRACTOR indemnifies and holds COUNTY harmless for any liability or responsibility for FEMA Category B cost reimbursements submitted and for the outcome of any PAS

administered through with said funds; and,

WHEREAS, the Parties desire to have this Agreement to memorialize their understandings and respective responsibilities for FEMA Category B funds that are passed through COUNTY to CONTRACTOR pursuant to the FEMA Category B program.

NOW, THEREFORE, in consideration of the foregoing Background and the recitals contained therein, which are incorporated into this Agreement herein below by reference, the parties agree as follows:

1. COUNTY agrees to submit FEMA Category B requests through FEMA protocols, for reimbursement of services including. but not limited to, coordination, transportation, food, shelter,durable medical equipment, effective communication access, health maintenance and PAS costs incurred by the CONTRACTOR, and to pass through any approved reimbursements to the CONTRACTOR with no other requirement or responsibility.
2. CONTRACTOR agrees to provide PAS for vulnerable congregate residents who reside in congregate settings in COUNTY.

(CONTRACTOR will provide and/or coordinate PAS in a cohort setting for residents of congregate settings in the county.)

3. CONTRACTOR agrees to provide all documentation of eligible costs for FEMA Category B reimbursement to the COUNTY and COUNTY for submission.
4. CONTRACTOR, in its administration of the FEMA Category B reimbursements, shall comply with all laws, regulations, terms and conditions of the FEMA Category B program as set forth by FEMA and shall comply with all other applicable federal, state, and local laws and regulations.
5. CONTRACTOR shall provide the COUNTY with completed reports required under the terms of the FEMA Category B program or otherwise required by the COUNTY, by forwarding copies to its Purchasing Office to ensure full compliance with the FEMA Category B program.
6. CONTRACTOR will provide the COUNTY, by forwarding copies to its Purchasing Office, with invoices and/or copies of the front and backs of checks to substantiate all use of the FEMA Category B program funds and compliance with FEMA Category B program requirements,

and shall maintain such records and keep them available for review by COUNTY and/or its agents.

7. Upon request, CONTRACTOR shall allow independent auditors or COUNTY's auditors access to the CONTRACTOR's records, financial and otherwise, in order to determine compliance with all laws, regulations, terms and conditions of the FEMA Category B program.

8. CONTRACTOR audit will be reviewed by COUNTY for the purpose of determining compliance or non-compliance. If non-compliance arises, CONTRACTOR will be directed to take corrective action. Upon direction to take corrective action, the CONTRACTOR will, in writing, inform the COUNTY of its timetable for implementation of the required corrective action and after the completion of the timetable, certify to the COUNTY the completion of the necessary corrective action.

9. In the event CONTRACTOR fails to comply with the requirements of the FEMA Category B program or of this Agreement, COUNTY may terminate the CONTRACTOR's further participation in the FEMA Category B program

through COUNTY or withhold payment of the FEMA Category B funds until all conditions are met.

10. CONTRACTOR shall indemnify, defend and hold COUNTY, its elected and appointed officials, officers, directors, agents, servants and/or employees harmless from and against any and all claims, demands, damages and causes of action arising out of or pertaining to any act or omission of the CONTRACTOR, its officers, directors, agents, servants and/or employees and for any costsincurred by the COUNTY arising out of the CONTRACTOR failure to comply with this Agreement or the FEMA Category B program. This indemnification shall cover COUNTY for any failure on the part of FEMA, its officers, directors, agents, servants and/or employees interms of any reimbursements made to or refused to CONTRACTOR.
11. Under no circumstance shall COUNTY be liable on any claims, demands, damages or causes of action arising out of or pertaining to any unavailability of the FEMA Category B program funds.

12. This Agreement shall be effective as of the _____, and shall expire, unless renewed by the Parties, on the_____.

MEMORANDUM OF AGREEMENT BETWEEN

_____

AND

_____

IN WITNESS WHEREOF, and intending to be legally bound hereby, this agreement has been executed this _____.

ATTEST

DATE

_____

COUNTY:

_____

Name and Title:

_____

Signature _____

Name and Title:

_____

Signature _____

Name and Title:

_____

Signature _____

ATTEST

DATE

_____

CONTRACTOR:

_____

Name and Title:

_____

Signature _____

Name and Title:

_____

Signature _____

Appendix E: Request for Reimbursement

Submit this form with a fee schedule (breakdown of expenses) invoices and receipts to match.

Name of Contracting Organization

_____

Start date of services_____

End date of services _____

Shelterees information

Age Group	Number of shelterees
0-2	
3-6	
7-12	
13-17	
18-21	
22-65	
66+	

Service information per housing unit

Housing Unit	Days of Stay	# of Meals	Other Services
1			
2			
3			
4			

Types of disabilities or access and functional needs

Number of household pets, assistance or service animals sheltered_____ Type of pet shelter provided:

- ☐ stand alone
- ☐ co-located
- ☐ co-habitational

Total expenses _____

SILVER Committee

Ron Bassman . . . . . Colorado
Janine Bertram . . . . . Washington
Clark Craig . . . . . Illinois
Misty Dion . . . . . Pennsylvania
Elissa Ellis . . . . . Arkansas
Rhoda Gibson . . . . . Massachusettes
Peter Grosz . . . . . Illinois
Pam Heavens . . . . . Illinois
Lydia Nunez . . . . . Texas
Tom Olin . . . . . Texas
German Parodi / Shaylin Sluzalis . . . . . Pennsylvania
Ebony Payne . . . . . Illinois
Barbara Pritchard . . . . . Illinois
Harriotte Hurie Ranvig . . . . . Massachusettes
Anaya Robinson . . . . . Colorado
Marcie Roth . . . . . Maryland
Lyndsay Sullivan . . . . . Illinois
Fran Tobin . . . . . Illinois

Additional Resources

Organizational Information, Guidance, Petitions

Administration for Community Living (ACL)
https://acl.gov/about-acl/administration-disabilities

FEMA regional offices directory
https://www.fema.gov/about/organization/regions

2016 ACL rule,"Independent Living Services and Centers for Independent Living"
https://www.federalregister.gov/documents/2016/10/27/2016-25918/independent-living-services-and-centers-for-independent-living

ACLU petition to HHS & CMS: "COVID-19 Response in Nursing Homes and Other Congregate Settings Where People with Disabilities Live" (June 23, 2020)
https://www.aclu.org/petition-covid-19-response-nursing-homes-and-other-congregate-settings-where-people-disabilities

> "Issue guidance to states directing them to grant immediate access to Independent Living Center staff, Aging and Disability Center Ombudspeople,

Protection and Advocacy staff, and others with expertise in transitioning people from institutions to the community, so that they may speak directly to all residents in congregate facilities, either in-person (with appropriate PPE provided) or via the internet, to introduce an offer of assistance for relocating and an assessment of each person's desire to move to a safer location, either temporarily or with the option to make a permanent transition to the community." p 22

SILVER PSA
https://vimeo.com/roustabout/silver1

Webinar: "Dying in Place? Addressing Infection Spread in Institutions (2020)
https://vimeo.com/roustabout/townhall1

Webinar: "Emergency Relocations & Non-Congregate Sheltering: Using Federal Disaster Recovery Resources" (May 2021)
https://www.youtube.com/watch?v=23DCy7INaZE

Article:" Roads to Freedom: Some residents ask to be transferred out of nursing home" (May 2020)
https://www.lockhaven.com/news/local-news/2020/05/roads-to-freedom%E2%80%88some-residents-ask-to-be-transferred-out-of-nursing-home/

Toolkit Survey

Feedback from you will help SILVER identify trends and issues related to emergency supports for institutionalized people. Please email the completed survey to silversurvey2022@gmail.com. We appreciate your support!

I represent:

- ☐ A Center for Independent Living (CIL)
- ☐ A non-CIL Community-Based Organization (CBO)
- ☐ A governmental agency

Other (please describe) _____

On a scale of 1 to 5 (1 = “strongly disagree”, 2 = “somewhat disagree, 3 = “neither agree nor disagree”, 4 = “somewhat agree”, 5 = “strongly agree”):

1	2	3	4	5	
					I was able to thoroughly review the Toolkit.
					The Toolkit had clear learning objectives.
					Before reading the Toolkit, I did not think CILs or CBOs should conduct emergency relocations.
					I will use the Toolkit in my work.
					This Toolkit increased the likelihood that I will act to support CILs or CBOs conducting emergency relocations.
					I will recommend the Toolkit to colleagues.

Other comments about the Toolkit:

Questions for CIL representatives only

During the first year of the COVID pandemic (1/2020 to 12/2020), the number of residents we helped transition from institutions:

- ☐ Increased significantly
- ☐ Increased somewhat
- ☐ Remained unchanged
- ☐ Decreased somewhat
- ☐ Decreased significantly

Between the first and second year of the COVID pandemic (1/2021- 12/2021), the number of residents we helped transition from institutions:

- ☐ Increased significantly
- ☐ Increased somewhat
- ☐ Remained unchanged
- ☐ Decreased somewhat
- ☐ Decreased significantly

From 1/2020 to now, what factors have affected your transition work from institutions?

If you would like to be contacted about future SILVER activities and resources, please complete the following

Contact Name _____
Title _____
Organization _____
City _____ State _____
Email address _____
Phone _____
Website _____

PLEASE EMAIL COMPLETED SURVEY TO:
silversurvey2022@gmail.com