SNAPS Office Hours

December 5, 2024

Housekeeping

➢ A recording of today's session, along with the slide deck and a copy of the Chat and Q&A content will be posted to the HUD.gov within 2-3 business days

➢ Event information for upcoming Office Hours, along with copies of all materials can be found here:

SNAPS Office Hours – HUD.gov

➢ If you cannot join by computer, you may dial in by phone only at 1-202-735-3323 with access code 6586486#.

➢ If you need additional help, call 1-301-250-7202.

Chat Feature

Select the Chat icon to make a comment or ask a question.

Speakers & Resource Advisors

<u>Department of Housing and Urban Development</u>
<u>Office of Special Needs Assistance Programs</u>

- Norm Suchar   - Karen Deblasio

<u>Office of HIV/AIDS Housing</u>
<u>Housing Opportunities for Person with AIDS Program (HOPWA)</u>

- Jeffrey Kiemen   - Katherine Pittenger

4

Speakers & Resource Advisors

Community Spotlight Presenters

- Victoria Mallette
- Carlos Laso

- Karina Garcia
- Manny Sarria

TA Spotlight Presenters

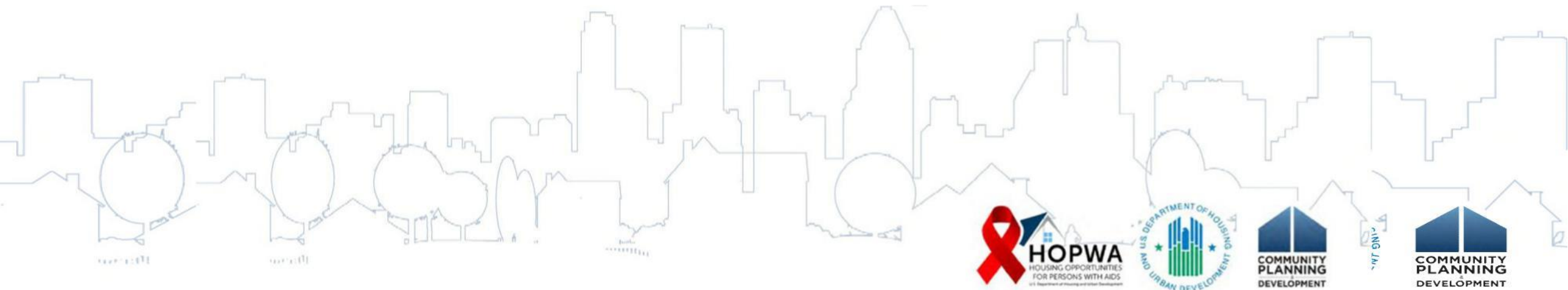- Melania Zamora
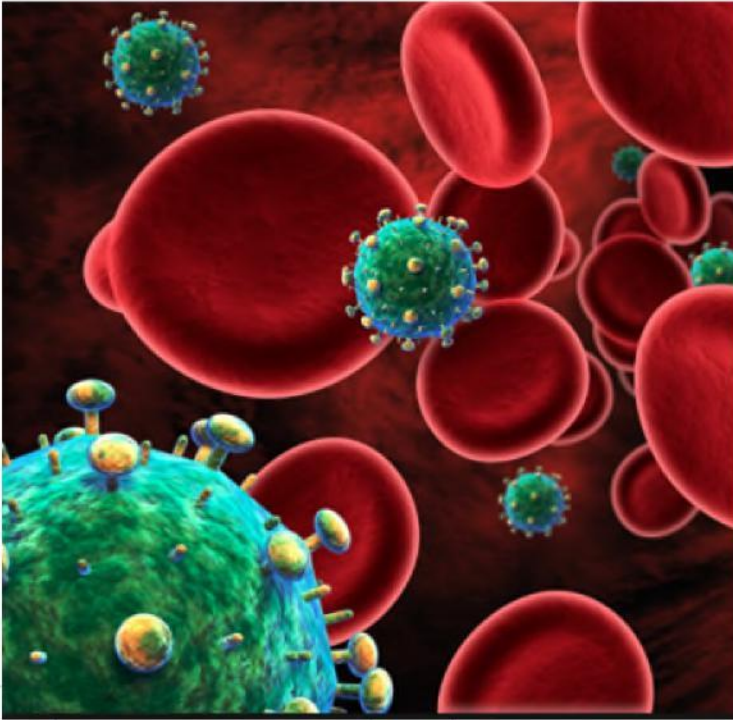- Gwen Beebe

- Jena Salon
- Nicole Libaire

Housing Opportunities for Persons With AIDS (HOPWA) Coordinated Entry

History and Purpose of the HOPWA Program

Understanding HIV today

- More than 1.2 million people in the U.S. are living with HIV

- In 2020, 30,635 people received an HIV diagnosis in the United States and dependent areas. The annual number of new diagnoses decreased 8% from 2016 to 2019.

- Statistics show a strong link between socioeconomic status and HIV

- HIV disproportionately affects African Americans as well as gay, bisexual, and other men who have sex with men

- The highest incidence rates of new cases can be found in the South (51% of new cases in 2020).

Learn more about HIV here:
https://www.cdc.gov/hiv/basics/index.html

What is HOPWA?

- HOPWA was established in 1992 by the AIDS Housing Opportunity Act (42 U.S.C. 12901)

- HOPWA is the only Federal program dedicated to addressing the housing needs of people with HIV.

- Under HOPWA, HUD makes grants to eligible cities, states, and nonprofit organizations to provide housing assistance and supportive services to low-income people with HIV and their families.

- There are local HOPWA programs in all 50 states, DC, Puerto Rico, and the US Virgin Islands.

- By providing housing assistance and supportive services, the HOPWA program helps people with HIV enter and remain in housing, access and maintain medical care, and adhere to HIV treatment.

Why Housing and HOPWA?

- Housing status is a social determinant of health that has a significant impact on HIV prevention and care outcomes.

- Homelessness and housing instability are linked to higher viral loads and failure to attain or sustain viral suppression and increased vulnerability for HIV acquisition. Housing instability is one of the most significant factors limiting the use of antiretrovirals, regardless of insurance, substance abuse, and other factors.

- Stable housing provides a foundation from which people can participate in HIV prevention services and is associated with reductions in behaviors associated with getting or transmitting HIV.

- People with HIV who achieve and maintain an undetectable viral load—the amount of HIV in the blood—by taking antiretroviral therapy (ART) daily as prescribed cannot sexually transmit the virus to others.

HOPWA Client Eligibility

There are two basic elements of HOPWA client eligibility:

1. Household has a least one person who is living with HIV. This includes households where the only eligible person is a minor; and

2. Total household income is at or below 80% of the Area Median Income (low-income as defined by HUD).

Grantees can further restrict eligibility based on local needs and accepted by HUD through the consolidated planning process or competitive application.

Eligible HOPWA Activities

- ❖ Facility-based and scattered-site emergency, transitional, and permanent housing
- ❖ Short-term rent, mortgage, and utility assistance to prevent homelessness
- ❖ Housing Development
- ❖ Permanent housing placement
- ❖ Housing information services
- ❖ Supportive services
- ❖ Resource identification
- ❖ Administration (by statute, 3% for grantees and 7% for project sponsors)*

Traditional Referral Process

- Historically, households seeking housing assistance and supportive services through the HOPWA program visited HIV/AIDS services organizations or their local health department, often through referrals made by other area agencies. In many communities, familiarity with the specific activities of the HOPWA program was limited to the HOPWA provider organizations, as other agencies were focused on operating their own specific programs and funding sources.

Current State of HOPWA and Coordinated Entry/HMIS

- Data Collection Requirements Formula and Competitive Programs may enter data into HMIS.

- Grantees that use homelessness or chronic homelessness in their program design as primary criteria for eligibility are encouraged to use an HMIS to track the services for their homeless clients. Additionally, some competitive awards also require grantees to use HMIS, per the grant agreement. While these grantees are required to use HMIS, all grantees – regardless of target population – are strongly encouraged to participate in a local HMIS, or equivalent, to track beneficiary-level data and outcome data.

- All HOPWA projects using HMIS are required to collect all of the Universal Data Elements and a select number of Program-Specific Data Elements

Methods for Integrating a HOPWA Program and a Coordinated Entry System: A Resource of Case Studies October 2021

- Where could HOPWA housing and services now be accessed?
  - Survey Administered: Alameda County, CA Baltimore, MD Kentucky Housing Corporation, KY Richmond, VA San Jose, CA Tucson, AZ State of Texas
  - 3 Major Case Studies – Baltimore, Tucson, Kentucky
  - What was found/worked well?
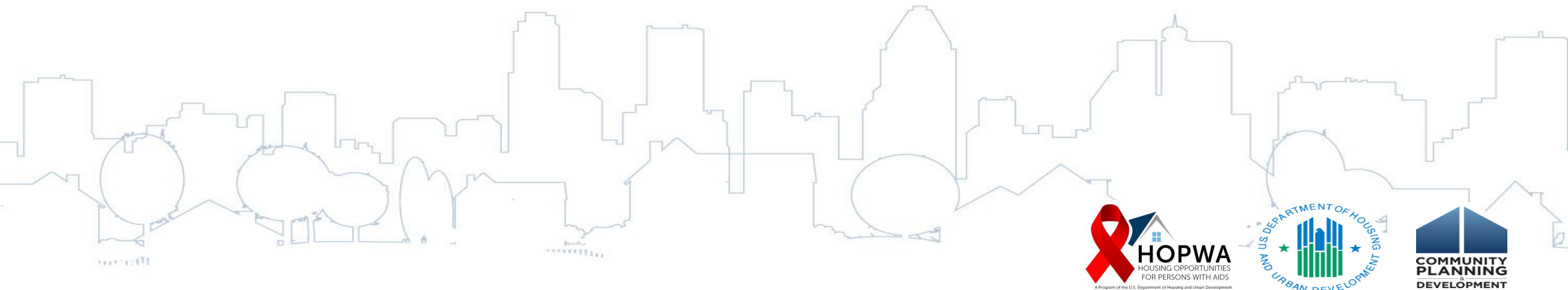
COMPARATIVE ELEMENTS AMONG CASE STUDIES

	HOPWA provider participation in the CoC and the CAS/CES planning Process	Assessment tool and HIV Status	Databases Used	Referral process for survivors of Domestic Violence	Confidentiality	Case Conferencing
Baltimore	HOPWA providers within Baltimore City participate in the CoC.	Baltimore uses a local vulnerability assessment tool rather than the VI-SPDAT.	HOPWA Providers are required to use HMIS; some also use CAREWare.	Clients who are survivors of domestic violence and are HIV positive may participate in a separate confidential CAS process through a Victim Services Provider (VSP) or can be referred directly to a VSP. In either situation, the VSP will coordinate with the HOPWA Team.	All client information is kept confidential and is only shared when a referral is made to the HOPWA team.	Baltimore HOPWA providers don't use case conferencing for housing assignments. Instead, they ask clients for their housing preferences and try to match them immediately when housing becomes available.
Tucson	SAAF participates in the CoC and was involved in development of the Coordinated Entry System Referral Policies and Procedures.	Tucson uses the standard VI-SPDAT question and adds a local question.	SAAF is required to use both HMIS and CAREWare	Clients who are survivors of domestic violence and are HIV positive are referred both to a Victim Services Provider and to SAAF. Their information is maintained in a separate secure database.	Only a client identification number can be seen by HMIS users; if more information is needed, the user must contact the referring agency.	HOPWA providers are present at case conferencing meetings when prioritization and housing placement decisions are made.
Kentucky	HOPWA Providers participate in the CoC and were involved in the CES Planning Process.	Kentucky uses a universal data element question at intake and the standard VI-SDPAT question.	Most HOPWA Providers use HMIS. If a provider doesn't use HMIS, a paper inclusion process is employed.	A separate and confidential process is in place for clients who are survivors of domestic violence and are HIV positive; after intake, they may be referred either to a Victim Services Provider or to a HOPWA provider, depending on any safety factors that may be involved.	All client information is kept in a secure location in HMIS and is only shared with a referral to a HOPWA provider.	Kentucky uses case conferencing to place clients in housing.

HOPWA
HOUSING OPPORTUNITIES
FOR PERSONS WITH AIDS
A Program of the U.S. Department of Housing and Urban Development

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

COMMUNITY
PLANNING
&
DEVELOPMENT

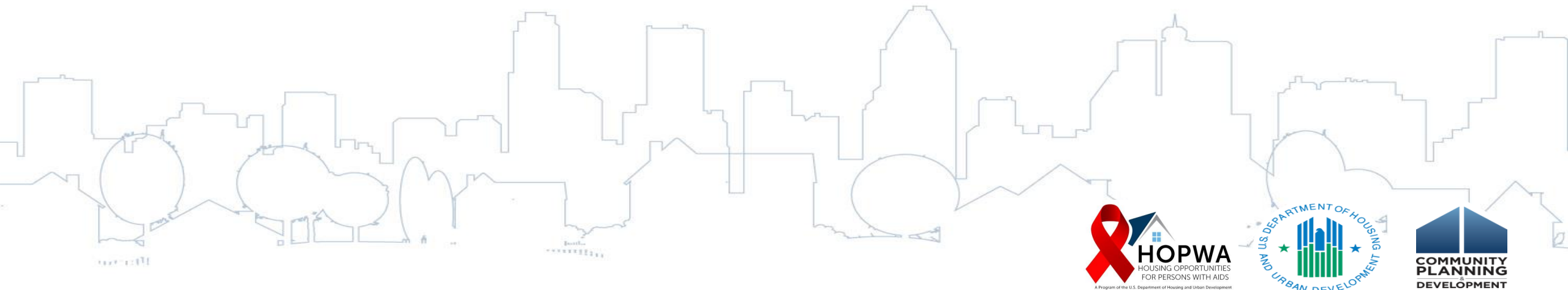# Recommendations for Coordinated with HOPWA and CoC

Engagement among HOPWA Providers and Continuums of Care is Key

- Participation by HOPWA providers on CoC committees can bring additional perspectives to all agencies.

- Creating partnerships can be mutually beneficial by opening new channels for referrals in both directions. Agency familiarity offers opportunities for warm hand-offs for clients.

- HOPWA providers and CES staff can discuss trauma-informed and culturally sensitive ways to ask clients about HIV status during CES intake; HIV status is sometimes grouped with other medical issues on assessment tools and can be overlooked. Awareness of HIV status provides opportunities for referrals to HOPWA services – both housing and non-housing.

- Value is added for both grantees and clients in potentially utilizing other resources and subsidies.

What can Coordinated Entry Organizations do if there local-HOPWA providers are not within the Coordinated Entry system and/or HMIS?

1. Find your local HOPWA grantees
2. Eligibility

How to Find Local HOPWA Grantees?

Grantees

Kentucky ▾

All Grantees ▾

Programs

☐ CDBG: Community Development Block Grant Program

☐ CoC: Continuum of Care Program

☐ Emergency Shelter Grants Program

☐ ESG: Emergency Solutions Grants Program

☐ HOME Investment Partnerships Program

☑ HOPWA: Housing Opportunities for Persons With AIDS Program

Kentucky ✕   HOPWA: Housing Opportunities for Persons With AIDS Program ✕

Export (xls)

State	Organization Name	Program	Contact Information
KY	Kentucky	HOPWA	**Point of Contact** Andrew Timleck Project Specialist I Kentucky Housing Corporation 1231 Louisville Road Frankfort, KY 40601 859-349-5044, Ext. 303 atimleck@kyhousing.org
KY	Kentucky	HOPWA	**Point of Contact** Kenzie Strubank Manager, Homeless Programs 1231 Louisville Rd Frankfort, KY 40601 502-601-0026, Ext. 138 kstrubank@kyhousing.org
KY	Louisville-Jefferson County, KY	HOPWA	**Point of Contact** Marilyn Harrison Director Louisville Jefferson County Metro Government 810 Barrett Ave., Suite 240 Louisville, KY 40204 502-574-3737 marilyn.harris@louisvilleky.gov

Grantee Information

Kentucky

- Overview
- CDBG
- Emergency Shelter Grants Program
- ESG
- HOME
- **HOPWA**
- HTF
- NSP
- RHP

Overview

Grantee Website

http://www.kyhousing.org/Pages/default.aspx

Recent Awards

Year	Program	Grant Type	Amount
2021	CDBG		$27,441,044.00
2021	ESG		$2,595,355.00
2021	HOME		$13,949,142.00
2021	HOME	ARP	$51,725,043.00
2021	HOPWA	Formula	$1,001,179.00
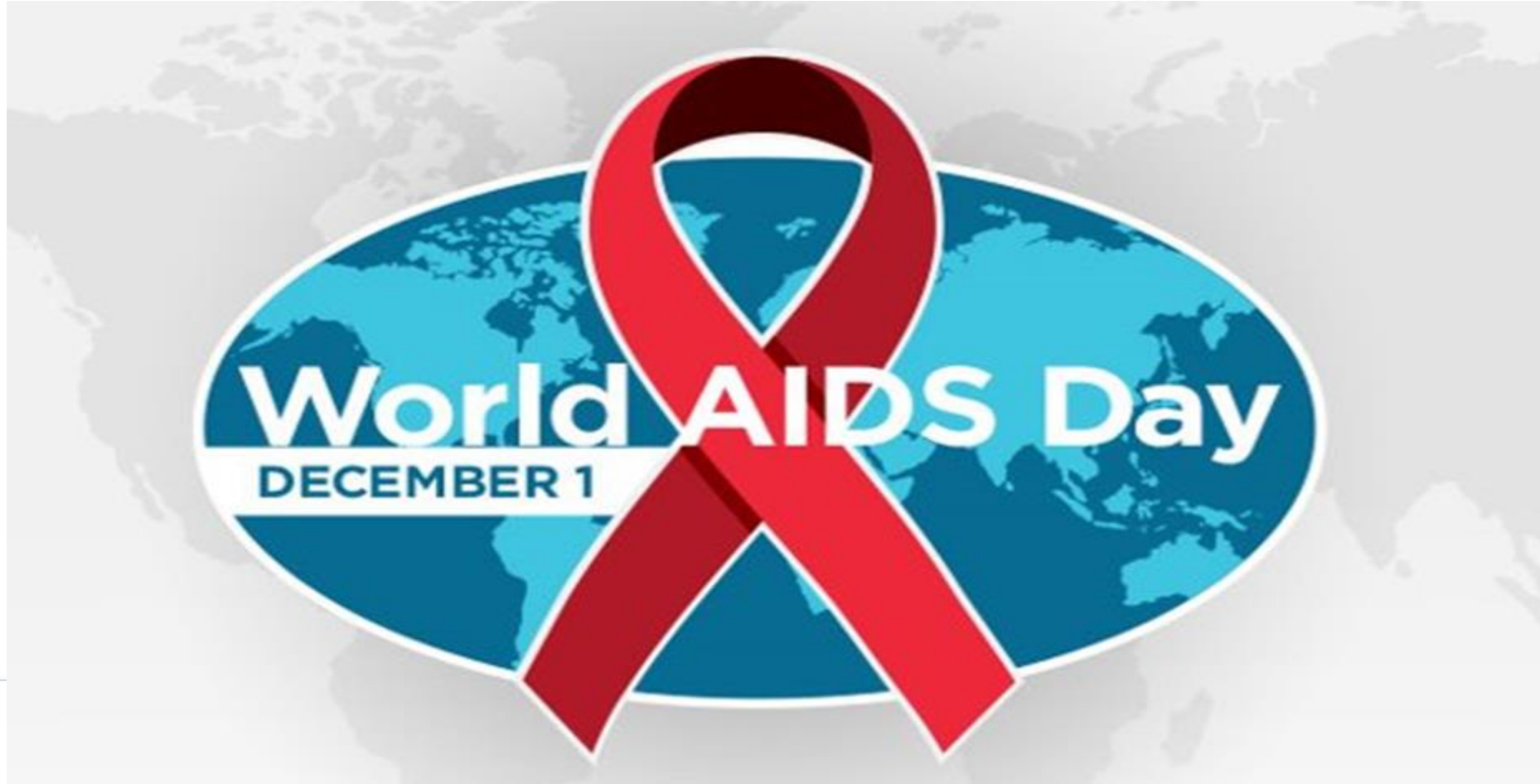
Resources

HOPWA/Coordinated Entry Integration Resource: [Methods for Integrating a HOPWA Program and a Coordinated Entry System: A Resource of Case Studies October 2021](#)

Find your HOPWA Grantee: https://www.hudexchange.info/programs/hopwa/

HUD Exchange HOPWA mailing list: https://www.hudexchange.info/mailinglist/subscribe/
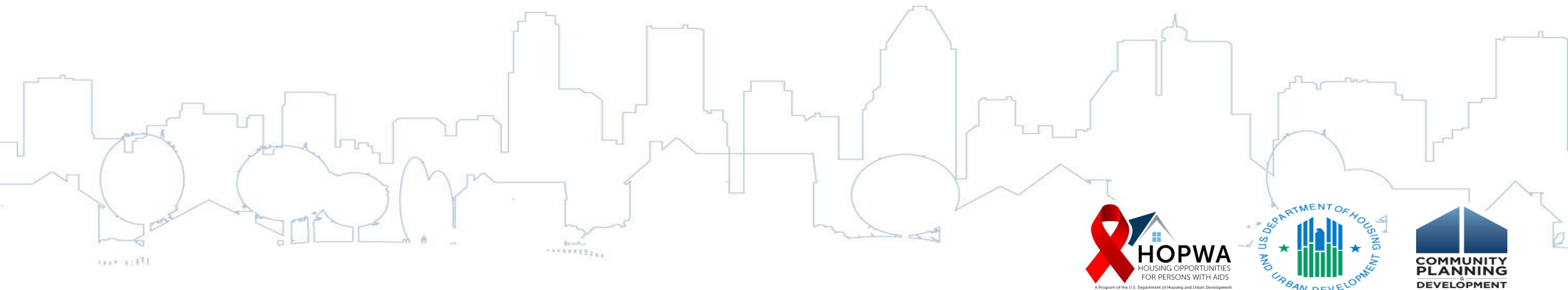
Contact

Jeff Kiemen

Pronouns: He/Him

Financial Operations Analyst

Office of HIV/AIDS Housing

U.S. Department of Housing & Urban Development

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202-402-7302

Housing Command Central (HCC)
Implementation for FL-600

HCC Launch

Fears
- Changing Coordinated Entry System
- Working with a new TA Team
- How will this affect the 1800 people who are sheltered

Concerns
- How would this be received by SO
- What, if any, are the negative consequences of these changes
- How will we be able to sustain this work
- Time and effort required by staff with pre-existing, full workloads

What emerged?
- Learning new strategies
- Working cohesively & learning from providers doing CES, ES/TH & PH
- CES teams shift to being more solution & housing focused
- Developed two new HMIS Assessments (a 3rd being developed for Housing Navigators)
- Creating key partnerships w/external systems
- Setting aside funds for move-in assistance cost
- Conversations with PHAs to adopt waivers

System Analysis

- HCC
  - Boots on the ground - work with unsheltered persons
  - Interviewing all direct service providers
  - Following referrals to identify system issues
- Nikki Case: Seeing Whole Systems
  - Change is not linear
  - Best results come from disrupting the system
- Moved from a systemwide, data driven prioritization approach
  - Geography based solutions
  - Data sharing with public hospital
- Solutions included looking at CoC financial & HMIS P&P

Key Elements – Work to Date

▸ Shift the perspective of the team to look across whole system

- Concrete methods for forming By-Name-Lists (BNL)
- Refine and standardize methods for documenting eligibility while expanding the range of approaches used to do so
- Review and calibrate resources at a systems level to resource and deliver needed elements of rehousing
- Eliminate (or minimize) process delays (Can we collect some documents after a client is housed?)

PROVIDER RESPONSE TO MODEL SHIFT

Required a willingness to be open-minded & collaborate

Boots on the ground TA promoted connection between TA & providers

BNL: Housing Coord. used solution focused questions & created a safe space

Outreach Model Changes

Problem-solving posture

Engagement tactics

Document handling

KEY PARTNERSHIPS TO LEVERAGE

Discharge planning with hospital and jails

Court

Social Security Office & DMV

Access Point services provided at library: Immigration office

Key Elements – Work to Date

- Recalibrating to Housing as the Goal
  - Outreach transition from crisis housing alone to being the guides that obtain permanent housing
  - Property owners and management companies are allies in this endeavor, and we need to strengthen the approach used to include them
  - Standardize housing application packages and encourage adoption of waivers to create more flexibility
  - Use technology to access to multiple units such as Padmission.

- Enhancing and refining methods for "meeting clients where they're at"
  - Start necessary work IMMEDIATELY (collecting housing documents: identification, social security, immigration status...)
  - Build and support mentoring among outreach, housing navigation, and program management staff to support shared learning and process fidelity

Stabilization Work

- Testing methodologies learned in other settings (hospital, feeding sites...)
- Continued collaboration with local PHAs to encourage smoother, swifter process for voucher issuance and unit inspection
- Embedding (or not) new methods into normal CoC practices
- Rethinking, at a resource level, the utilization of funds, match and donations

Future

- Sharing data with public hospital who provides largest emergency and crisis services, along with Corrections Health.
- CoC obtaining real-time notifications when clients are admitted.
- Leveraging new contact/emergency contact information, hospital navigators, discharge instructions/location
- Prioritizing unsheltered people who are highest system utilizers

Housing Systems and Processes in Development

Key Components

✓ Regular coordination meetings ensure alignment and address emerging challenges in real-time.

✓ Collaborative problem-solving with housing navigators to develop innovative solutions and overcome obstacles.

✓ Centralized inventory management provides a clear overview of available units, facilitating efficient allocation and tracking.

✓ Dedicated Navigator-landlord facilitation bridges communication gaps, fosters positive relationships, and accelerates the housing process.

Expected Outcomes

✓ Significantly reduce the time it takes to secure stable housing for individuals and families in need.

✓ Enhance program partnerships by fostering collaboration, resource sharing, and a unified approach to housing navigation.

✓ Streamline communication channels between housing stakeholders for efficient information flow.

✓ Develop long-term systemic solutions that address the root causes of housing instability and promote sustainable change.

Housing Navigation Plan

1   Centralized Housing Inventory

Develop a dynamic, shared inventory of available housing units, ensuring real-time updates through collaborative platforms and tools.

2   Streamlined Referral System

Establish an efficient, HMIS-based referral process for seamless client tracking and support. Implement a Lead Navigator program to address complex cases and provide specialized assistance.

3   Support for Complex Housing

Implement landlord incentives and eviction settlement programs to encourage housing stability. Proactively address systemic barriers faced by those experiencing homelessness.

Miami's housing navigation system is undergoing a transformative evolution through a strategic partnership with the Homeless Trust and HCC Team. This collaborative initiative aims to streamline processes, enhance efficiency, and effectively address the complex housing needs of Miami's most vulnerable populations.

QUESTIONS?

Housing Central Command (HCC) TA
HUD Office Hours

Presented By :
HCC Team

Presentation For :
HUD Office Hours

Date :
12-05-2024

What is HCC?

An approach to rehousing that is grounded in Disaster Approaches

—

Over the past 15 years, SNAPS has provided **CoCs on the ground support** following major catastrophic disasters like **pandemics, hurricanes, and wildfires**.

In the last five years, SNAPS has **utilized the homelessness disaster approach in jurisdictions that were not experiencing a major catastrophic event** as a strategy to activate rehousing for unsheltered households in encampments.

While the tools activated in an emergency are well practiced by the disaster technical assistance team, they **had not been used as a planned approach for areas not facing a disaster until recently**.

Features of HCC

Inclusive
Community invited to participate.

Adaptable
Adaptable and flexible to changing needs on the ground.

Efficient
Time Limited and intensive focus.

Integrated
Connect with many elements of homelessness response system.

Focused
Focused on rehousing households that are unsheltered.

Accountable
Whole community accountable for sustaining development

Responsive
Daily rehousing and problem solving.

HCC GOALS

Rapid Placements

Accelerate placements into permanent housing.

Build Capacity

Develop capacity in a community to identify eligible households, identify available units, match and move households into eligible units.

Clear Focus

Improve efficiency of moving unsheltered people directly from the street into housing.

HCC TEAM STRUCTURE

1

TRANSITION 1

2

TRANSITION 2

3

INITIATION
Activator & Mentor

LOCATION
Remote/Onsite

OBJECTIVE
Design
Infrastructure

ACTION
Discover Gaps
& Barriers

FOCUS
Project Management,
Activate/Delegate Solutions

IMPLEMENTATION
Local Leadership Coach

LOCATION
Primarily Onsite

OBJECTIVE
Co-Create Sustainable
Infrastructure

ACTION
Bridge Gaps &
Resolve Targeted Barriers

FOCUS
Modeled Problem
Solving Orientation

SUSTAINABILITY
Practitioner Champion

LOCATION
Primarily Remote

OBJECTIVE
Support Local Maintenance
of Infrastructure

ACTION
Reconcile Temporary Efforts
& Embed Sustained Solutions

FOCUS
Refine Problem
Solving Orientation

SME SUPPORT
Strategic Guide

LOCATION
Primarily Remote

OBJECTIVE
Refine Infrastructure

ACTION
Refine & Resolve Gaps

FOCUS
Eliminate Ambiguity

Project Management/ Support
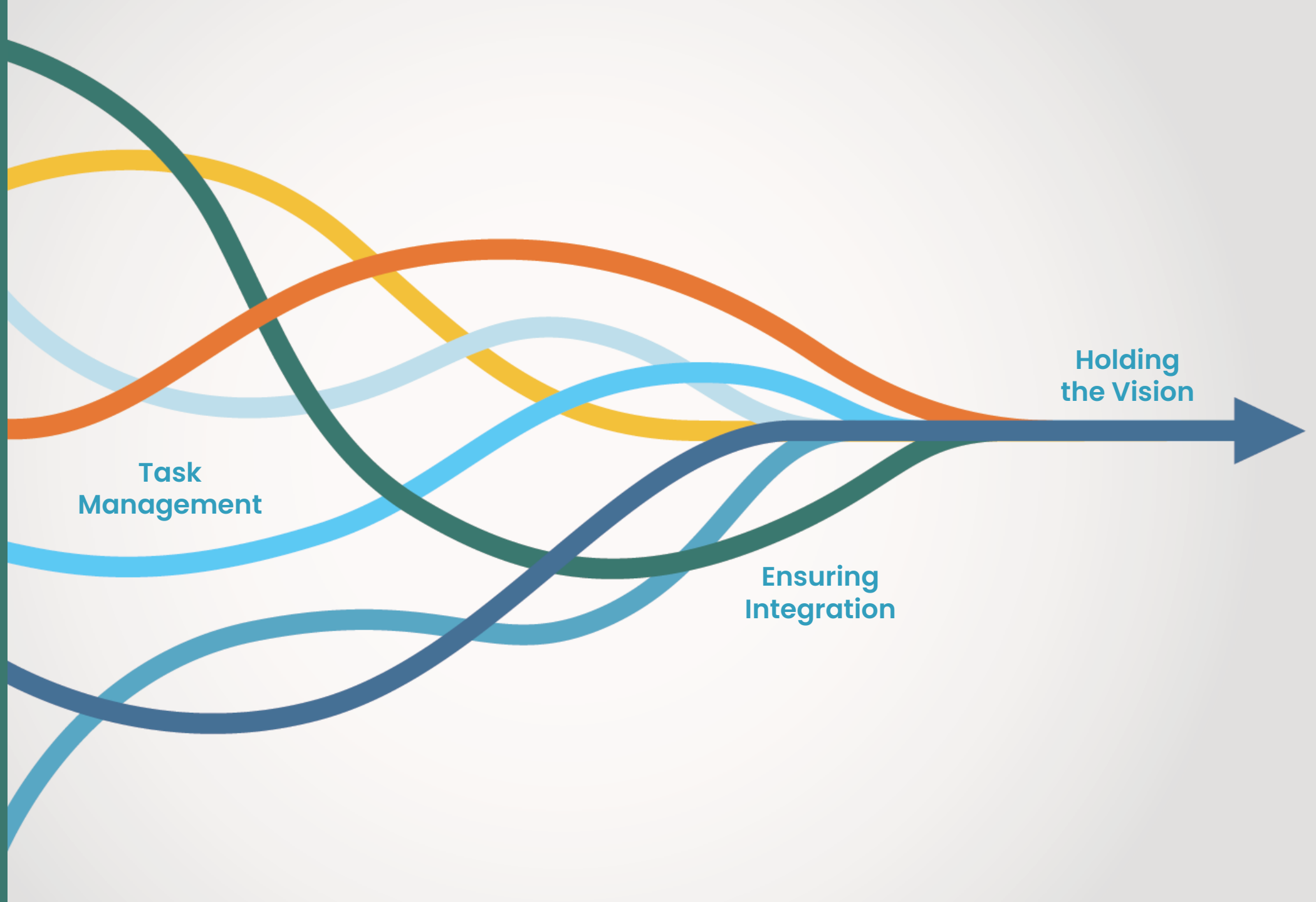
Task Management
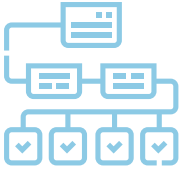
- During daily meetings, noticing and operationalizing:
  - Themes
  - Highlights
  - Action items
  - Implications of actions
  - Community reactions
  - Team needs and reactions

- Identifying the correct levers to pull and activate

- Communicate information to relevant parties in adjacent workstreams

- Task Management

- Documentation Management: all resources, products, tasks

Ensuring Integration
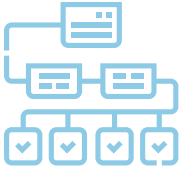
- General understanding of each strand of work, its purpose and how it connects to other pieces

- Daily participation in most team and community meetings

- Identifying new strand of work

- Creating a visual representation of inventory and work and how all the pieces fit together so Team understands how their goals and tasks fit into the greater system

  - This looks like: systems mapping, workflows

Holding the Vision
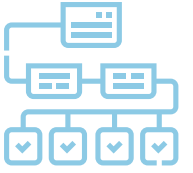
- **Goals and vision of HCC Initiative**: HCC Core Team

- **Goals of the local instance**: HCC Community Team

- **Activating in a community looks like:**

  - Collaboration with community leaders

  - Process Flows

  - Documenting Expectations

  - Mapping tasks and plans to overall vision

  - Onboarding and supporting new members

EXAMPLE OF WORKFLOW

OVERVIEW

Engage Household → **Determine Financial Assistance Type** → **Secure Unit & Move-In** → **Support Household in Housing**

POTENTIAL PROGRAM STAFF COORDINATION MODELS*

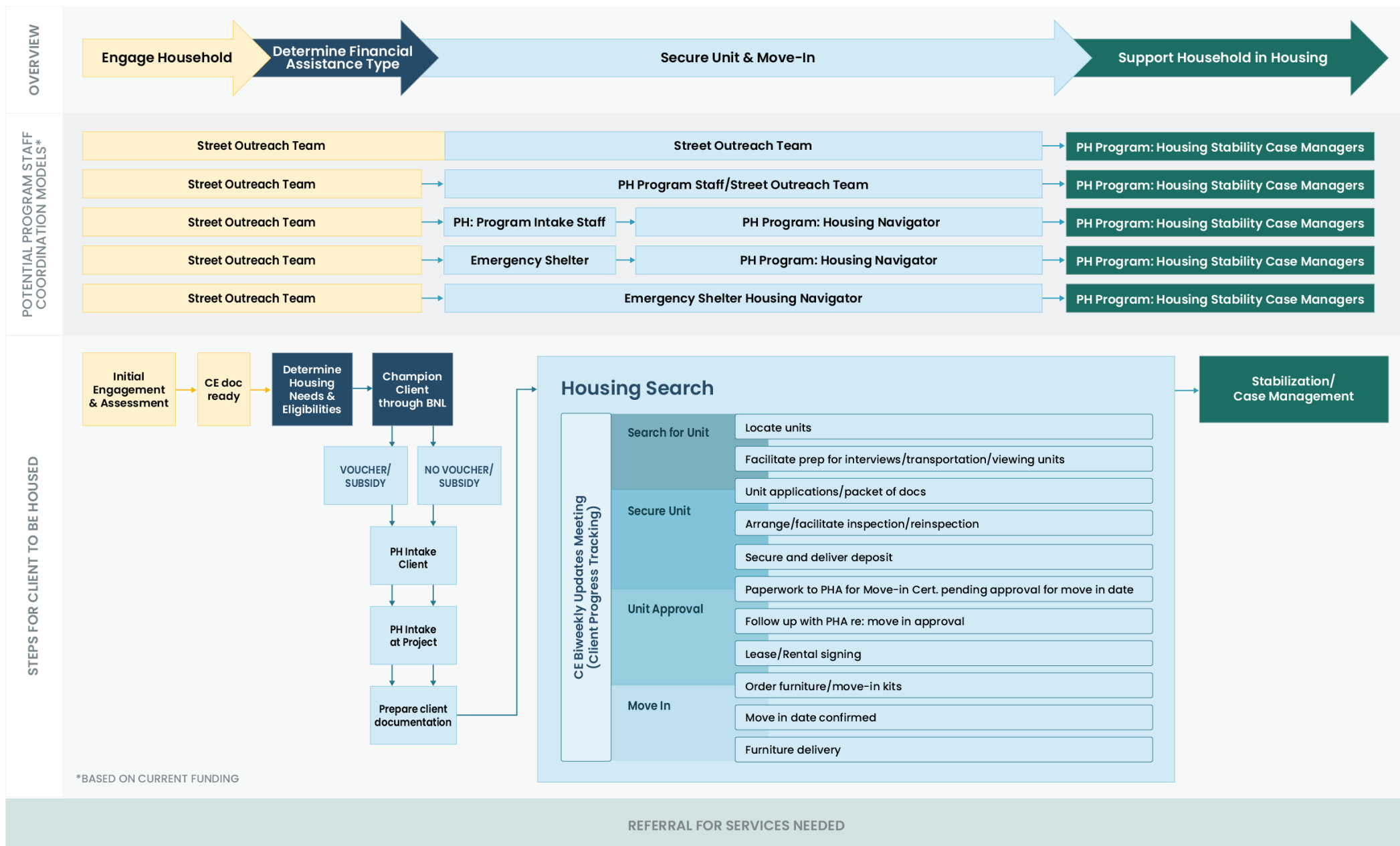| Engage Household	Secure Unit & Move-In	Support Household in Housing
Street Outreach Team	Street Outreach Team	PH Program: Housing Stability Case Managers
Street Outreach Team	PH Program Staff/Street Outreach Team	PH Program: Housing Stability Case Managers
Street Outreach Team	PH: Program Intake Staff → PH Program: Housing Navigator	PH Program: Housing Stability Case Managers
Street Outreach Team	Emergency Shelter → PH Program: Housing Navigator	PH Program: Housing Stability Case Managers
Street Outreach Team	Emergency Shelter Housing Navigator	PH Program: Housing Stability Case Managers

STEPS FOR CLIENT TO BE HOUSED

Initial Engagement & Assessment → CE doc ready → Determine Housing Needs & Eligibilities → Champion Client through BNL

- VOUCHER/SUBSIDY
- NO VOUCHER/SUBSIDY

→ PH Intake Client → PH Intake at Project → Prepare client documentation

Housing Search

CE Biweekly Updates Meeting (Client Progress Tracking)

Search for Unit
- Locate units
- Facilitate prep for interviews/transportation/viewing units

Secure Unit
- Unit applications/packet of docs
- Arrange/facilitate inspection/reinspection
- Secure and deliver deposit

Unit Approval
- Paperwork to PHA for Move-in Cert. pending approval for move in date
- Follow up with PHA re: move in approval
- Lease/Rental signing

Move In
- Order furniture/move-in kits
- Move in date confirmed
- Furniture delivery

→ **Stabilization/Case Management**

*BASED ON CURRENT FUNDING

REFERRAL FOR SERVICES NEEDED

Using Data & HMIS to Support HCC

HMIS Community Assessment

Coordinated Entry Prioritization Assessment

Community Partners and Data Sharing

Key Performance Indicators and Monitoring

Baseline

- Identification of how HMIS and data is currently leveraged

- Understanding what degree of data literacy currently exists in the community

- Determination of which gaps are limiting the ability to understand who is in unsheltered situations

Encampment Data Collection

- Identification of how the community currently understands who is in any given encampment

- Determination of how much encampment data collection occurs in HMIS, if any, and what other tools may be in use

Revisions and Updates

- Support to leverage HMIS and data to understand who is residing in targeted encampments

- Includes a communications strategy to assist HMIS Leads/System Administrators and direct service providers in speaking the same language

HMIS Community Assessment

Coordinated Entry Prioritization Assessment

Community Partners and Data Sharing

Key Performance Indicators and Monitoring

Focus on Rehousing

- Identification of questions that need to be added or modified to support the rehousing effort directly from encampments

- Determine what disparities currently exist in the homeless response system and how the community can account for them in any prioritization revisions

- Engage in a continuous quality improvement cycle with the updated prioritization process

Report Development

- Modifications to prioritization reports to account for updated prioritization process

- Includes direct support to update reports, as well as capacity building with HMIS Leads/System Administrators and Coordinated Entry leadership to maintain reports over time

- Develop report to leverage newly collected HMIS data to support encampment understanding

Dashboard Development

- Development of dashboard for the community to understand progress over time

- Updated at regular intervals

- Includes specific steps of the process and simple metrics

- Ability to disaggregate by race/ethnicity to monitor equity

HMIS Community Assessment

Coordinated Entry Prioritization Assessment

Community Partners and Data Sharing

Key Performance Indicators and Monitoring

Data Sharing

- Important aspect of effectively serving people experiencing homelessness

- Support to the community to understand how data can be shared, with whom, and what agreements need to be put into place

Partners

- Determination of cross-system partners also interacting with people in unsheltered situations and gaps that exist in partnerships with them

- Facilitation of discussions about consent, purpose, and process of data matching

- Ensuring there is a clear vision for the purpose of the data sharing

Addressing Barriers

- Determine at what point the disparity is starting

- Gather qualitative feedback and information

- Use the information to make shifts and engage in continuous quality improvement processes to understand what impacts the shifts have

Key Performance Indicators and Monitoring

- HMIS Community Assessment
- Coordinated Entry Prioritization Assessment
- Community Partners and Data Sharing
- **Key Performance Indicators and Monitoring**

Plan and Do

- Developed with key metrics and points in the process – assessed, referred, enrolled, housed
- Updated at least weekly

Check

- Reviewed regularly to understand progress
- Disaggregated by race/ethnicity
- Identification of trends that show one subpopulation is being served more effectively than another

Act

- Determine at what point the disparity is starting
- Gather qualitative feedback and information
- Use the information to make shifts and engage in continuous quality improvement processes to understand what impacts the shifts have

Mobilizing the Data

- Understanding **how different subpopulations are successfully navigating different phases** of the process (i.e., assessment, referral, document readiness, enrollment, housed) supports local decision making on resource allocation

- Understanding **where and when disparities emerge** is necessary to limit their impact

- **Updating data dashboards on a regular and frequent basis** permits identification of disparities early so that effective strategies can be implemented

- The **impact of solutions**, and shared understanding of where additional resources may be needed, is **strengthened by consistent monitoring of progress** including disaggregating data by race and ethnicity

Mobilizing the Data

	American Indian, Alaska Native, or Indigenous	Black, African American or African	Hispanic/ Latina/e/o	Multi-racial – Includes Indigenous	Multi-racial - Other	Native Hawaiian or Pacific Islander	Unknown	White
People on HCC List								
People Still at Encampments	57%	29%	21%					8%
Assessed	100%	86%	98%	100%	100%	100%	100%	98%
Referred	36%	43%	67%	57%	100%	100%	75%	76%
Enrolled	36%	14%	49%	29%	67%	100%	0%	46%
Doc-Ready	57%	14%	49%	43%	67%	100%	0%	52%
Apps Submitted								
Housed	36%	29%	40%	29%	67%	100%	0%	48%

Specific Community Examples

Formalize Data & Knowledge Sharing

Conversations between large health system and CoC leadership to formalize data sharing process for high utilizers and people experiencing unsheltered homelessness

Process to Ensure Data Accuracy and Interpretation

Support to troubleshoot dashboard metrics and determine how data quality and/or communication strategies needed to shift to ensure accurate quantitative data is used to understand progress

Rapid, equitable, iterative decision-making

Rapid decision-making process to update and implement prioritization schema for people in unsheltered situations, explicitly incorporating equity perspective and support determination if updated process amplified or mitigated disparities

Capacity Building to Track & Manage Process

Capacity building with HMIS team as HCC leveraged HMIS to track encampments, prioritize people, and understand progress

Public Housing Authorities

Opportunities working with PHAs

Notice PIH 2024-17

HOTMA flexibilities available now re:

- Self-certification of SSN with one third party document like a cell phone bill or benefit letter
- Third party document valid for 120 days
- Self-certification of zero income

Streamlined waiver approval process for:

- Self-certification of disability and date of birth
- Self-certification of income

MORE Opportunities for working with PHAs!

Notice PIH 2022-18

Using HCV admin fees to assist families to lease units

- Owner incentive and retention payments
- Security deposit assistance
- Utility deposit assistance/utility arrears
- Application fees/non-refundable administrative or processing fees/refundable application deposit assistance/broker fees
- Holding fees
- Renter's insurance

EVEN MORE
Opportunities
for working
with PHAs!

Notice PIH 2023-13, CPD 2023-05

Using HCV admin fees to assist families to lease units

- Preference for referrals from the CoC's CES

- Simplify the application process

- Reducing barriers related to criminal activity and substance use

- Move on strategies

Resources

- CoC Program Competition | HUD.gov / U.S. Department of Housing and Urban Development (HUD)

- ESG and ESG-CV Reporting Office Hours - HUD Exchange

- COVID-19 Homeless System Response: Emergency Solutions Grant Program (ESG-CV) Close Out

- Process (hudexchange.info)

- https://www.hudexchange.info/programs/hdx/guides/pit-hic/#general-pit-guides-and-tools

- https://www.hudexchange.info/homelessness-assistance/resources-for-lgbthomelessness/

- https://www.hudexchange.info/resource/4951/equal-access-staff-training-scenarios/

- https://www.hudexchange.info/programs/fair-housing/lgbtqia-fair-housing-toolkit/

- http://www.hud.gov/vawa

Questions?