Mayors Challenge

Additional Resources

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HUD-VASH Best Practices – Version 1.0

A Working Document

April 2012

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

Introduction

Federal agencies and our partners around the country are committed to achieving our shared goal of ending Veteran homelessness by 2015. The successful implementation of the Departments of Housing and Urban Development and Veterans Affairs Supportive Housing (HUD-VASH) program is essential to realizing this goal and other goals identified in the Federal Strategic Plan to Prevent and End Homelessness. Since the revival of HUD-VASH in 2008, we learn on a daily basis about new and better ways to implement the program and ensure that Veterans are stably housed. Because HUD-VASH continues to be a work in progress, we decided to compile these best practices into a working document that will be edited when effective new approaches are identified and not-so-helpful ones are discarded.

In the fall of 2011, a request for the submission of best practices was sent to public housing agencies (PHAs) and VA Medical Centers (VAMCs) that administer the program via the HUD-VASH listserv. Over 50 best practices accounts were submitted in response to the request. The practices below have been compiled based on these accounts, which were cross-referenced with monthly data on agency performance and further developed through phone interviews. Subsequent emails, reports, and conversations exchanged among federal agencies, PHAs, and other partnering entities have informed and will continue to inform this best practices list.

The purpose of this working document is to spread the word about effective strategies for administering HUD-VASH, as well as highlight the innovation and dedication of HUD-VASH sites and our partners in the field. Because it was HUD that compiled this list of practices, the document is somewhat skewed to a PHA point-of-view, and it largely focuses on practices that enhance and streamline leasing processes. In the future, we hope to expand the section on successful retention and attrition, as well as create a section on strategies for best serving Veterans experiencing chronic homelessness.

For additional information on successful strategies from the VA point-of-view, a wealth of knowledge can be found in the VA's HUD-VASH Resource Guide and other helpful tools on the VA's National Center on Veteran Homelessness website. General information on helping individuals and families experiencing homelessness can be found on HUD's Homelessness Resource Exchange and the U.S. Interagency Council on Homelessness (USICH) website.

A list of individuals that have generously contributed best practices information can be found at the end of this document. Feedback, comments, and practices recommended for inclusion in future versions of our best practices list can be sent to kaitlin.miller@hud.gov. Thank you for your contributions and assistance with this project, and keep up the great work!

Milan Ozdenic, Deputy Assistant Secretary
Office of Public Housing and Voucher Programs
Department of Housing and Urban Development

Best Practices Categories

1. Strategies for expediting application and leasing processes

As noted by the Fort Worth Housing Authority, the expeditious processing of HUD-VASH applications "is important in establishing the relationship with the Veteran and maintaining the connection and their belief that they can be housed." Partnering agencies have recognized this importance and have altered traditional practices in order to house HUD-VASH applicants as quickly as possible. A common denominator in these practices is the simultaneous completion of one or more tasks, which deviates from the linear, step-by-step methods that PHAs normally use to process Section 8 Housing Choice Voucher (HCV) applications. Many of these practices also may help PHAs to streamline their application and admission processes for their regular HCV programs.

- **Trainings:** The West Haven and Fort Worth housing authorities both recommend holding trainings for case managers on income verification and the completion of HCV applications in order to further expedite these processes. In general, providing periodic trainings for staff from partnering organizations and agencies on PHA and VA topics helps the program to run more smoothly at all stages of Veterans' participation. The Columbia Housing Authority and partnering VAMC provide short trainings on different topics at each monthly meeting, such as HQS inspections, the types of housing units that are acceptable, and the services and supports needed by Veterans.

- **Preparing for VA benefit applications and screening for HUD-VASH case management eligibility:** The Los Angeles VAMC and community partners have implemented a number of strategies to accelerate the application processes for VA case management. For example, non-profit organizations that work with homeless Veterans have been trained in helping Veterans to acquire their military service documentation, or the DD 214 form, and assessing whether or not the Veteran will be eligible for HUD-VASH. In addition, the Los Angeles VAMC has a consultation line that organizations can call with questions regarding Veterans' eligibility for HUD-VASH and other VA benefit programs. The VAMC also has trained LA County staff answering 211 calls on the eligibility requirements for VA benefit programs, including HUD-VASH case management. As a result of these strategies, when Veterans arrive at the VAMC to submit applications, VA staff spend less time helping Veterans to acquire documents and determine whether or not they qualify for the program.

- **HCV application completed before meeting with the PHA:** A very widespread practice is for the PHA to provide all forms and a list of documents required for the HUD-VASH application to the VAMC. Case managers work with Veterans to fill out the forms and compile all documents prior to meeting with the PHA and submitting applications. The Kenner Housing Authority asks the VA case managers to fax copies of all documents prior to the meeting in order to review them (if PHA staff have time) and start a file for the Veteran.

- **Simultaneous HCV application completion and housing search:** The West Palm Beach VAMC gives Veterans the voucher application and housing search packet at the same time,

and the VAMC works with Veterans to complete the application while also searching for a unit. Subsequently, when Veterans attend orientations at the West Palm Beach Housing Authority, they submit both their applications and Requests for Tenancy Approval (RTAs). This has reduced the number of days in the leasing process by an average of 15 days.

- **Issuing of a provisional voucher while completing check for lifetime sex offender registration:** The Long Beach Housing Authority (LBHA) has found that it takes up to a week to confirm whether or not a Veteran is on a lifetime sex offender registry. In order to save time, the agency does a preliminary check on the national sex offender search tool, and if the Veteran is not on the list, he or she receives a provisional voucher. The Veteran then begins looking for a unit to rent with a provisional voucher while LBHA waits for official confirmation on sex offender status from the FBI database. It is estimated that this practice has eliminated 7 days from the HUD-VASH leasing process. For more information, see the USICH online article here.

- **Ensuring unit will pass the Housing Quality Standards (HQS) inspection:** A NYHCR local administrator includes an HQS checklist in their "Move Packet" given to Veterans issued a HUD-VASH voucher. When a Veteran finds a unit, the owner initials the checklist stating that the unit meets those specific HQS qualifications. The checklist then is submitted with the RTA. It provides the owner and applicant information on HQS and allows them to walk through the unit ahead of time to ensure the items on the checklist meet those standards.

- **Simultaneous HQS inspection and rent reasonableness determination:** Instead of one department of a PHA completing the HQS inspection and another negotiating rent-reasonableness with the landlord, the Long Beach Housing Authority began allowing for both the inspection and rent reasonableness determination to be completed at the same time. It is estimated that combining these requirements has eliminated 21 days from the HUD-VASH leasing process. For more information, see the USICH online article here.

- **Developing a pool of pre-inspected units:** The Washington DC VAMC contracted out case management responsibilities to the DC Department of Human Services, which then enlisted a local organization, the Community Partnership, to carry out the housing search process. Along with the DC Housing Authority, the four agencies worked together in order to streamline leasing processes for HUD-VASH. Among the new strategies the agencies applied was tasking the Community Partnership with recruiting landlords and identifying available units. Pre-inspections were completed, and a pool of potential units subsequently was developed from which HUD-VASH Veterans had the option of choosing. These and other strategies applied by the Washington DC HUD-VASH partners reduced the average number of days in the leasing process from 6 months to 1 month. See a more in-depth assessment of DC's system redesign here.

- **PHA contracting-out of referral to lease-up activities:** As the target population for HUD-VASH has shifted to chronically homeless Veterans, the City of Phoenix Housing Department (CPHD) began exploring opportunities to increase collaboration with

community partners for serving this vulnerable population. CPHD decided to contract-out the leasing functions of its 150 HUD-VASH vouchers from the FY 2011 allocation. After issuing an RFP, CPHD selected for the contract HOM, Inc, the largest provider of permanent supportive housing for individuals and families experiencing homelessness in Maricopa County. Beginning in January 2012, HOM, Inc. began receiving referrals of eligible homeless Veterans directly from the Phoenix VAMC and determining eligibility for the HUD-VASH vouchers. HOM, Inc. conducts briefings, issues vouchers, assists with the housing search process, processes RTAs, determines rent reasonableness, calculates tenant rent and housing assistance payments, performs HQS inspections and facilitates the execution of leases between HUD-VASH participants and community landlords. CPHD uses money from its unrestricted net assets (UNA) account to fund the contract, paying nearly the same amount of money it costs to pay a CPHD staff person to complete the same activities. Because of HOM, Inc's experience and expertise in serving homeless individuals and families, chronically homeless Veterans have been housed more quickly.

- **Carrying out a system redesign or process-mapping workshop**
  - The national non-profit, Community Solutions, and staff working on their 100,000 Homes Campaign, have organized housing placement "boot camps" in New York and Los Angeles to help HUD-VASH sites streamline their leasing processes. Facilitated through an incremental process-improvement method designed by the Institute for Healthcare Improvement, boot-camp participants are divided into community teams and asked to map out the current housing placement process. The time to complete each step of the process then is estimated and included on the process road map. After reviewing the current processes, participants are then asked to create a more "ideal" system that streamlines activities, combines or completes multiple tasks at once, and helps homeless Veterans move into housing faster. Intense brainstorming sessions take place, with participants "accepting responsibility for driving change within his/her agency" in order to reduce steps and time involved in the process. Written individual and team action plans then are established.
  - External facilitators are helpful for system redesign events or "boot camps." The 100,000 Homes Campaign staff from Community Solutions can be contacted about carrying out housing placement boot camps for HUD-VASH: www.100khomes.org.
  - System redesign efforts also can be carried out internally within a single agency in order to accelerate the steps in the referral and leasing processes for which the agency is responsible. For example, in August 2011, the West Palm Beach VAMC organized internal meetings and system review workshops with HUD-VASH staff from the VA's Veteran Integrated Service Network (VISN) 8 to explore ways that HUD-VASH activities can be accelerated.

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2. PHA management strategies

The following management strategies are simple steps initiated and carried out by PHAs that have significantly influenced the overall success of HUD-VASH sites.

- **Identifying designated PHA staff to focus on HUD-VASH:** Eight responders emphasized the value of designating one or more staff people at PHAs to serve as HUD-VASH experts and points of contact for VA staff. PHAs have recognized the importance of having staff with skill sets and knowledge unique to HUD-VASH that develop strong working relationships with VA staff.
    - Columbia Housing Authority has assigned one staff person to be the VA's contact for Veteran applications, another person to be the contact on leasing, and a third person to be the VA's contact on inspections.
    - After identifying employees to focus on HUD-VASH, the Fort Worth HA arranged for the designated staff to be trained on effective approaches for working with homeless, disabled Veterans.
    - The Orange County Housing Authority designated a staff person to be a liaison with VA case managers. The housing authority also held a training for multiple staff members on VASH program objectives in order for staff to gain understanding and support for processing Veteran families differently.
    - The Minneapolis Public Housing Authority (MPHA) emphasized the importance of "putting a 'face' behind the VASH program" on the PHA side to offer reassurance and a "communal element" for Veterans applying to the program. In the words of Andrew Ailes from MPHA, "from the shelter to program completion, Veterans know who their contact is at the PHA. There is a familiar and responsive person they know that sits behind their paperwork."
- **Setting aside one day of the week for HUD-VASH intake:** A number of PHAs recommend designating one day of the week for Veteran application submissions and orientation. The regularly scheduled day for these procedures helps to establish structure and shared expectations for the application process for the PHA, VAMC, and most importantly, for the Veterans.
    - Kenner Housing Authority designates the entire day on Fridays to VASH meetings. The agency provides refreshments for Veterans and tries to personalize the process as much as possible to help Veterans feel comfortable.
- **Providing space for VA case manager(s) in PHA's office:** Four PHAs that responded to our request for best practices reported that their agency provides an office or other type of workspace for VA case managers in their agency's building. Such an approach enhances coordination, communication, and efficiency in administering the program.
    - The Longview HA reports that from the day the VA staff arrived and settled in, the agencies have created and maintained a symbiotic partnership that includes face to face

conversations/interaction, prompt exchange of documents, and follow-up Veteran engagement that has greatly lessened the Veteran's stress level, their time on the street, and enhanced their overall housing experience.

- The VA partnering with the Myrtle Beach Housing Authority initially did not have a case manager located in Myrtle Beach. The travel to Charleston made it very difficult for the Veteran to comply with the VA program requirement in order to qualify for housing assistance. Therefore, the housing authority decided to provide space for the case manager in their office. When the housing agency's waiting list was opened up for two days, the VA case manager being onsite made it easier to reach any Veterans who were applying for the regular HCV waiting list. Together they were able to reach many Veterans who did not know about the HUD-VASH program.
- The Butte County Housing Authority maintains that giving office space to the VA case manager enabled "both housing staff and the VA to meet with and see clients in the same building, in a coordinated effort, minimizing inconvenience and hassle to a population that has transportation issues and an aversion to working with multiple public institutions."
- The Yakima Housing Authority reports that housing VA staff in their office "eliminates the Veteran needing to go to more than one place to meet with staff from either source. Think of a one-stop shopping place."

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3. VA management strategies

The following management strategies are simple steps initiated and carried out by VA facilities that have significantly influenced the overall success of HUD-VASH sites. Extensive lists and explanations of other VA strategies for HUD-VASH can be found in the VA's HUD-VASH Resource Guide.

- **Including peer support specialists on HUD-VASH teams:** For the Orlando VAMC, a combination of clinical case management and peer support services has proven to be extremely effective for engaging and assisting homeless Veterans. A peer support specialist is a Veteran that serves as a role model for HUD-VASH Veterans by sharing his or her own experiences with mental health issues and coping tools to overcome personal challenges. After being issued a voucher, Veterans in Orlando are matched with peer support specialists, who provide guidance and camaraderie throughout the Veterans' participation in the program and help quell anxieties and uncertainties along the way. The peer support specialists are able to quickly relate to Veterans, build rapport, broaden Veterans' social networks, and help Veterans stick to their plans and achieve their goals.
- **Dividing VA staff into teams that focus on specific communities:** The Greater Los Angeles VA Health System has divided HUD-VASH system into teams that focus on

serving Veterans that lease-up in specific neighborhoods within the metropolitan area. This strategy has enabled VA staff to become more familiar with the culture and politics of specific communities and develop working relationships with local organizations. As a result, VA staff have increased their engagement and enrollment of Veterans, and they are more effectively helping Veterans to navigate through community before and after leasing-up. This staffing approach, as solidified at the Los Angeles HUD-VASH boot camp in June 2011, is particularly helpful for HUD-VASH sites in large metropolitan areas with large allocations of vouchers.

- **Imbedding case managers in the communities where Veterans reside:** Typically, HUD-VASH case managers work from offices located in VA medical clinics. The VAMC in Bedford, Massachusetts, decided to place case managers in community shelters, PHA offices, and local Vet Centers, which enables the case managers to improve outreach to homeless Veterans, while still meeting the needs of current HUD-VASH clients. The VAMC has found that this practice has improved Veterans' attendance to appointments and adherence to treatment plans, and it has fostered more effective working relationships with community partners.

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4. Assistance with security deposits and move-in costs

Hands down, the most common obstacle faced by Veterans during the lease-up process as described by HUD-VASH sites is a lack of funds for security deposits and other move-in costs. The Homelessness Prevention and Rapid Rehousing Program (HPRP) has served as an important resource for many sites across the country to address such needs of Veterans. However, HPRP funds have been depleted, and, as a Housing and Economic Recovery Act program, the funds will not be renewed. A few sites that found HPRP funds difficult to access developed unique strategies for assisting Veterans with these expenses, which can help those sites that previously depended on HPRP:

- **PHA revolving loan fund:** Butte County Housing Authority's Board of Commissioners authorized a $10,000 revolving loan fund from its unrestricted General Fund to assist Veterans with move-in costs. The VA Services Coordinator determines the amount of funds necessary in each case, and determines the terms of the repayment agreement, based on any particular Veteran's capacities and need.

- **Revolving loan fund through partnership with local banks:** Yakima housing authority also provides loans to Veterans with funds secured through local banks' community reinvestment dollars. The money is repaid by the Veterans in small increments, which refuels the loan fund and acts as a revolving account.

- **Maryland Veterans Trust Fund:** The Maryland Department of Veterans Affairs (MDVA) has set up the Maryland Veterans Trust Fund through legislation passed during

the 2009 session of the Maryland Assembly. The legislation authorizes MDVA to receive donations, then make grants and loans to Veterans in dire financial situations and to private organizations helping Veterans. Numerous corporations and individuals have made large donations to the fund, which are tax deductible under state law as well as Title 26, US Code, Section 170. MDVA has made a few donations to HUD-VASH participants for security deposits and other move-in costs. The agency has expressed interest in attending HUD-VASH briefings held by Maryland PHAs, at which HUD-VASH Veterans could submit applications for assistance from the Trust Fund. ***Staff at MDVA collected information on 20 other states that have a Veterans trust fund.***

- **Community Development Block Grants:** Early in the program, the Myrtle Beach Housing Authority (MBHA) contacted the landlord and utility companies to ask for their help with security and utility deposits. This was not always successful and was very time consuming. MBHA subsequently applied to the Horry County Community Development Block Grant (CDBG) program and received funds to assist with the deposits. The VA caseworker determines the need and assists the Veteran with the required documentation. A check for all or a portion of the deposits is issued as part of the lease up process.

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5. Assistance with furniture and other household items

Most Veterans participating in HUD-VASH also need help with furnishing their homes and acquiring towels, sheets, silverware, and other household items. As described by the Butte County Housing Authority, "it was found that there is nothing more chilling to a program participant than to make it all the way through the lease-up process and then walk in to a home devoid of furniture and the things necessary to the keeping and enjoyment of a home." Innovative strategies in this area include:

- **Community outreach:** Columbia Housing Authority's (CHA's) Homeless Programs Department began reaching out to the community to "recycle" gently used and new items for the VASH and PSH programs. CHA created a brochure, as well as carried out press releases, local radio interviews for this effort. As a result, CHA received the following donated items:
    - The Judicial Advocacy Center donated 2400 towels, 600 pillows, 400 bedspreads, lamps, irons, and chairs while doing a hotel renovation over the last 6 months.
    - The contents of a local hotel that had changed owners were donated to include bedroom furniture and televisions.
    - Fifty beds and side tables were obtained when Fort Jackson Military Installation was scheduled to demolish an old barracks.
    - Numerous donations from local citizens

Some items were distributed to low-income families served by CHA, but some were held in a warehouse to be used by VASH clients. CHA will be meeting with the hotel association and contacting all hotels in the area to replicate this practice.

- **Thrift store partnership:** The Butte County Housing Authority established an informal partnership with a faith-based entity, whose thrift shop serves as the source of furnishings and household goods for many program participants.

- **Furniture packages and gift cards:** A non-profit organization assisting with the HUD-VASH program in Washington, DC, the Community Partnership, successfully negotiated furniture packages with local vendors for every Veteran participating in HUD-VASH. The organization also persuaded landlords to allow furniture to be delivered in advance of lease-signing and receipt of initial rental payments, so clients could move in to furnished apartments. Finally, the Community Partnership coordinated the provision of department store gift cards that were used by clients to obtain basic household necessities.

- **Free use of storage unit:** The VA clinic in Pensacola, Florida, partners with the organization, Opportunity Inc, to assist HUD-VASH Veterans with furniture and other needs as they move in to their units. A storage facility in Pensacola has provided a free storage unit to Opportunity Inc, which the organization uses for storing household items donated by families and local businesses. After signing a lease, HUD-VASH Veterans visit the storage unit to pick up items for their new homes.

- **Adopt-a-room campaign:** Although not benefitting HUD-VASH households, this innovative practice by the Housing Authority of the City of Santa Barbara (HACSB) is worth including in this report. In November 2010, HACSB launched the Adopt-a-Room Campaign to furnish the apartments of a new development for low-income families, disabled individuals, and youth aging out of foster care. Through the campaign, HACSB partnered with the non-profit, 2nd Story Associates, to request and receive $350 donations from vendors, businesses and community members for furniture and other household items for the new apartments.

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6. Recruiting landlords and finding units

Another primary challenge faced by many HUD-VASH sites is a lack of decent, affordable apartments with amenable landlords. A prolonged housing search puts at risk Veteran's trust and commitment to sticking with the program. Many responders cited strategies for recruiting landlords, while others described methods for helping Veterans to find units. For example:

- The Des Moines Housing Authority worked with the VA to develop a flyer to send out in monthly HAP checks to landlords leasing units to regular HCV program participants. The flyer informed property owners about the VASH program and described the support

provided by VA case managers to help Veterans pay rent on time, etc. As a result, property owners contacted the VAMC and expressed interest in renting to participating Veterans.

- Raleigh County Housing Authority held open forums in several different locations at which they explained the VASH program and how it serves homeless Veterans. Several landlords now only house VASH participants for the simple reason that they are Veterans.
- The Waco VAMC has developed and maintains an updated list of available units in the VA's catchment area that are potential housing options for Veterans.
- The Fort Worth Housing Authority (FWHA) has a staff member whose primary responsibility is to expand housing opportunities for the homeless through the education and recruitment of landlords. HUD-VASH Veterans benefited from this existing landlord outreach program, which FWHA had established to assist with other homeless housing programs.
- A NYSHCR local administrator always writes "VASH" on the vouchers when issued so that when a Veteran expresses interest in a property, the landlord recognizes them as Veterans and gives them first preference.
- The Oakland VAMC has a contractual agreement with the non-profit, Eden Information & Referral, to assist Veterans with their housing search.
- The New Jersey VAMC has compiled a resource book consisting of apartment complexes and landlords to assist Veterans and case managers with finding units.
- The VA has made available funding for VAMCs to hire **housing search specialists** that build relationships with landlords, keep track of available apartments, and help Veterans find and lease units. Case managers often assist with these tasks when the PHA does not have the capacity carry them out; however, case managers with full caseloads typically lack both the time and expertise to take on these tasks. Therefore, many VAMCs have taken advantage of this funding and have found and hired individuals with housing backgrounds for these positions. For example, the West Los Angeles VAMC hired a real estate agent with extensive knowledge of the area's housing market to serve as the site's HUD-VASH housing search specialist. The 100,000 Homes Campaign has provided a sample job description of a housing search specialist on their website.

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7. Ensuring Veteran Retention and Positive Attrition

The first version of this document focuses mainly on activities that help streamline and expedite the HUD-VASH leasing process. In future versions, an equal if not stronger focus should also be placed on retention and making sure that Veterans, if and when they exit the program, do so for positive reasons. We will not be able to realize our goal of ending Veterans homelessness by 2015

if the Veterans we serve do not achieve and sustain housing stability. Therefore, to expand this section, HUD will continue researching and soliciting contributions on retention and helping Veterans become more self-sufficient.

A preliminary practice that should be highlighted under this section is the linking of HUD-VASH with HUD's Family Self-Sufficiency program.

- **Connecting Veterans with the Family Self Sufficiency (FSS) program:** FSS is an employment and savings incentive program for families receiving Section 8 HCV or public housing assistance. It consists of 1) FSS coordinators hired by PHAs to help participants pursue employment and other goals, and 2) interest-bearing escrow accounts established for each participating family. The PHA credits to the escrow account increases in rent that a family normally would pay due to increases in earned income during the FSS contract of participation. The PHA may make a portion of this escrow account available to the family during the term of the contract to enable the family to complete an interim goal. If the family completes the contract and no member of the family is receiving cash welfare assistance, the amount of the FSS account is paid to the head of the family. More information on the FSS program can be found on HUD's website, here.

  HUD identified two PHAs with high numbers of HUD-VASH families participating in FSS and called the PHAs to learn more about their programs: the Cecil County Housing Agency (CCHA) and the Housing Authority of the City of Long Beach (HACLB). Nearly 20% of the Veterans participating both agencies' HUD-VASH programs have also participated in the agencies' FSS programs. More research and assessment needs to be completed on the extent to which the linking of the programs help Veterans to remain stably housed and successfully "graduate" from HUD-VASH. However, ***it is clear that HUD-VASH and FSS are mutually beneficial and the gains made by Veterans are enhanced and accelerated when the two programs are linked.***

  Below are key points that PHAs made regarding the value of linking the two programs and effective practices for doing so.

  - The FSS coordinator and VA case manager positions compliment each other, broaden the support provided to Veteran, and increase the likelihood that Veterans are able to achieve personal goals. As stated by HACLB, the FSS coordinator is a member of the "village" that cheers Veterans on and helps them to be successful.
  - CCHA stated that many of the HUD-VASH Veterans participating in FSS are a bit rusty at first with literacy and math and sometimes have trouble completing forms. However, the Veterans often are more driven and disciplined than other FSS families that are not in HUD-VASH. They also have more training, education, and credentials than the average FSS participant.
  - Constant dialogue between the FSS coordinator and VA case manager is key. CCHA asks the Veteran to officially confirm his or her interest in FSS by filling out a form,

which the case manager then signs. This helps to ensure that the FSS coordinator and VA case manager are on the same page from the start.

- A VA case manager is a member of CCHA's FSS Coordinating Committee, which the housing agency states is valuable for ensuring that the FSS program effectively meets needs of HUD-VASH Veterans.
- Both PHAs stated that it has been helpful having FSS staff attending HUD-VASH briefings in order to inform Veterans to FSS and encourage them to participate.

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8. System development and maintenance through regular communication

The establishment and maintenance of regular communication practices was mentioned by almost all respondents as a key factor influencing long-term program effectiveness. Providing information to all partners about the status of each applicant, as well as Veterans already leased-up, ensures that no Veteran slips through the cracks and that potential problems can be prevented. Many respondents described the importance of PHA staff and VA case managers copying each other on every email and other types of correspondence related to Veteran applicants and participants. Respondents also stressed the importance of having regularly scheduled meetings in order to discuss and address problems, explore strategies for improvement, and ensure understanding of policies and responsibilities.

- The HUD-VASH Coordinator of the Waco VAMC gathers the status of every Veteran in the catchment area and forwards the information on a weekly basis to every case manager and to the Waco Housing Authority.
- The Lexington VAMC keeps staff at the Lexington Fayette Urban County Housing Authority informed via email of any changes in income, household composition, or other issues that may affect Veterans' housing.
- The HUD-VASH partners in DC developed an automated communication system in which all partners exchange information on the status of Veterans' housing applications and the identification and availability of units. The Department of Human Services enlisted the help of the D.C. Office of the Chief Technology Officer to develop customized, web-based project management software for the purposes of enhanced data sharing that would track both housing identification and client movement through the housing process. The VAMC in Tampa reports that the facility's HUD-VASH Coordinator has developed a similar automated system for tracking Veteran's status in the housing process.
- For smaller HUD-VASH programs, the spreadsheet developed by staff from the Harrisburg Housing Authority and Camp Hill VA facility is an example of a simple but very useful tool for keeping track of Veterans' status. Veterans' names are listed vertically in the first column, then horizontally are listed different types of information on the Veteran, such as

voucher issuance and expiration date, sources of income, inspection date and whether or not the inspection passed or failed, reinspection date, etc.

- The Des Moines Housing Authority management staff meet quarterly with VAMC case managers in order to identify barriers to finding housing or address other issues that Veterans and VA staff are facing.
- The Columbia Housing Authority and VAMC meet together to improve the program on a monthly basis. At each monthly meeting over the last year, the two agencies have educated each other on how these programs can work together. Topics discussed at meetings include HCV rent calculations, HQS inspections, and what kinds of housing units are acceptable. Representatives are also available at the monthly meetings to discuss the supportive services needs of the clients and possible community resources. The housing authority maintains that all of these efforts have helped obtain and keep Veterans in the program.
- Beyond having regular meetings and exchanges of information, the Vermont State Housing Authority maintains that the success of the PHA and VAMC partnership "hinges heavily on understanding how each organization works and the interpersonal relationships developed between VAMC staff and PHA staff."
- The Oakland Housing Authority emphasizes the need for communication to be both open and honest, ensuring that partnering agencies have the freedom to let each other know when mistakes have been made. Flexibility and willingness to try different approaches also ensures that the partnership remains strong and the system continues to improve.

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9. Establishing, supporting, and relying on new partnerships

Successful HUD-VASH sites work with a variety of program partners that often go beyond the traditional networks of social service providers and government agencies. Such partners include continuums of care, homeless shelters, Veterans Halls, Veterans of Foreign Wars (VFW) offices, county and state offices of Veterans' services, private businesses, private housing developers, faith-based institutions, and school district homelessness liaisons.

- Prior to the hiring of a VA case manager, the Butte County Housing Authority conducted outreach with dozens of such entities and was able to establish a substantive list of homeless Veterans interested in program participation.
- The Des Moines Housing Authority recommends maintaining contact with many different service providers in order for them to keep HUD-VASH in mind when they are working with a Veteran.
- The Community Partnership in Washington, DC developed relationships with a number of businesses, including Target, which has provided gift cards to HUD-VASH Veterans for

the purchasing of household items after signing a lease. As described under Practice #6, a number of PHAs and VAMCs have made similar connections with local vendors to help Veterans with furniture and other household items.

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10. Effective coordination between city, county and state PHAs

All housing agencies work with other housing agencies that operate in a nearby community or that serve the county or state area. Establishing a system for ports and other shared activities involving HUD-VASH among PHAs with adjacent jurisdictions can eliminate future headaches and confusion. Many PHAs emphasized, as well, the value of sharing best practices and strategies for addressing common problems with other HUD-VASH PHAs in the same metropolitan, county, or state area.

- The Housing Authority of the City of Los Angeles (HACLA), the Housing Authority of the County of Los Angeles (HACoLA), and the Long Beach Housing Authority have created a uniform HUD-VASH housing application for use by all three agencies in order to reduce time and confusion on the part of VA case managers.
- In addition, HACLA and HACoLA have signed an MOU that allows the agencies to execute HAP contracts for HUD-VASH in each others' jurisdictions. The Georgia Department of Community Affairs (the Georgia State PHA) and the Fulton County Housing Authority signed an interagency agreement to similarly administer vouchers in the other PHAs' jurisdictions. Such arrangements eliminate the administrative burden of portability and give Veterans a wider selection of housing options nearby. PHAs interested in a such an arrangement need to verify that leasing in another PHA's jurisdiction is allowable under state law.
- The Massachusetts Department of Housing and Community Development (DHCD), the state public housing agency, serves as a leader and coordinator of other PHAs administering HUD-VASH in Massachusetts. DHCD hosts a quarterly working group for all HUD-VASH PHAs, VAMCs, and other stakeholders in the HUD-VASH program. The meeting serves as an open forum where participants provide updates on leasing rates, challenges, and best practices. DHCD also provides information and facilitates discussion on topics timely to the program, such as the FY 2010 Notice of Funding Availability (NOFA) for project-based VASH vouchers. This assistance has allowed PHAs, VAMCs, and developers to better coordinate their efforts to prepare successful proposals and bring more Veterans' housing to the region.

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11. Dedication to Veterans served

The most common denominator among all effective and efficient HUD-VASH programs is a high level of dedication and commitment to the Veterans served. Drawing on this dedication, successful agencies put a great deal of effort into the program at the front end, with less activity and urgency required later in the program after Veterans have been housed and the majority of vouchers have been utilized.

- **Making an extra effort:** Other PHAs make special efforts to go the extra mile to ensure that Veterans are comfortable. For example, the Oakland Housing Authority conducts in-home briefings if requested by clients, while the Minneapolis Public Housing Authority holds initial intake appointments at the VA so that new clients' introduction to HUD-VASH is in a comfortable environment. For Western New York partnering agencies, when a Veteran wishes to live outside of Erie County, staff from the Belmont Housing Resources for Western New York drive with the VA Case Manager to meet up with the Veteran. The agencies gather paperwork, orient the client, meet the landlord and conduct an inspection of the prospective unit. As described by Sean Lindstrom of Belmont Housing Resources, "I have a very close working relationship with the case managers of the homeless program at the Buffalo VA. If it were not for our mutual dedication to our Veterans we would not be able to communicate and work as effectively as we do."

- **Prioritizing HUD-VASH:** Many PHAs reported efforts made to prioritize all activities related to HUD-VASH applications, such as income verifications and HQS inspections. The Fort Worth Housing Authority clearly marks "VASH" on the files of Veterans so that staff in all departments know that processing should be expedited when a VASH file or document hits their desk.

- **HUD field offices chipping in:** All HUD field offices around the country have demonstrated extraordinary commitment to HUD-VASH and to helping partnering agencies ensure that Veterans are stably housed. It is impossible to list here all of the innovative practices implemented by field offices in support of HUD-VASH partnering agencies. A few examples, however, are provided below.

    - Staff from the field office in Louisville, KY, have organized a "Dash for VASH" initiative that involves outreach efforts at shelters, community centers and church soup kitchens to spread the word about available HUD-VASH vouchers. Individuals working in multiple HUD departments, as well as VA employees, participate in these periodic events.

    - In Jacksonville, FL, staff from the Public and Indian Housing (PIH) field office have reached out to organizations that are military friendly (such as the American Legion and Fleet Reserve Association) to inform them about gaps in program funding. The organizations now provide funds for security deposits and other move-in costs for homeless Veterans participating in HUD-VASH.

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12. Dedication to ending homelessness

Another common denominator among the most successful HUD-VASH sites is a high level of dedication not only to the HUD-VASH program, but also to broader efforts to end homelessness. Effective agencies have demonstrated their understanding of the interconnectedness of HUD-VASH and these broader community efforts, as well as how homeless programs depend on each other for addressing client-specific needs, exchanging knowledge, attracting resources, and building community support for a common cause.

- **PHA homeless programs:** The Butte County, Columbia, Fresno, and Fort Worth Housing Authorities all have staff and/or offices designated specifically to serving homeless families and administering homeless programs. These agencies have demonstrated heightened awareness of the importance of HUD-VASH within their communities' continuums of care for the homeless. Their HUD-VASH programs have benefitted from the knowledge base, relationships with landlords, and partnerships with service providers that had already been established, enabling the efficient processing of HUD-VASH applications and leasing of new vouchers.
- **Alternatives to VASH:** For those homeless and/or low-income Veterans that do not qualify for VASH, other housing assistance options often are limited or difficult to access. With this in mind, the Las Vegas VAMC, the HUD field office in Las Vegas, and community partners organized a "HUD-VASH Alternatives" housing fair for those Veterans that did not qualify for HUD-VASH and were homeless or at-risk of experiencing homelessness. The event took place on November 21, 2011, and 61 Veterans attended. Participating vendors included grantees of the Supportive Services for Homeless Veterans (SSVF) program, Habitat for Humanity, and Consumer Credit Counseling. The partnering agencies will hold another HUD-VASH Alternatives fair in May that applies lessons learned from the first fair, which include:
    - Ensure that the vendors that attend can offer housing assistance and other resources that Veterans can access immediately.
    - Have a sufficient number of VA staff and other agency staff or volunteers on-hand to help Veterans fill out applications.
    - Hold separate fairs for different groups of Veterans (i.e. women, older Veterans, etc) with the vendors that attend offering services and assistance that meet the unique needs of each group.
    - Ensure that the space for the event and resources offered can accommodate the number of Veterans that are likely to attend.

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Best Practices: Sharing Information to End Veteran Homelessness

A document of the HUD-VA Federal 100-Day Workgroup

In cooperation with a 4-community focus group

Purpose

This document seeks to provide guidance for local homeless Veteran service providers to improve information sharing across programs and systems, strengthen the targeting of resources based on a shared prioritization system, and create more efficient systems for ending Veteran homelessness within their communities. These local providers primarily include members of Continuums of Care funded by the US Department of Housing and Urban Development (HUD) and staff of US Department of Veterans Affairs (VA) medical centers.

Background

In recent years, HUD and VA, in collaboration with the U.S. Interagency Council on Homelessness (USICH), have changed the way they work on Veteran homelessness at the federal level in response to a growing understanding of the need for collaboration. Similar collaboration is needed at the local level, where the real work is done to end homelessness among Veterans. This document provides guidance requested by communities to facilitate the information sharing needed for further collaboration between local Continuums of Care (CoCs) and VA Medical Centers (VAMCs).

Many communities across the country have participated in "boot camps" hosted by Community Solutions and the Rapid Results Institute, and sponsored by HUD, VA, and USICH. These boot camps bring together national leaders and representatives of local government, CoC, Public Housing Agencies, and VAMCs to ask communities to make specific 100-day commitments to improve their local system's ability to end homelessness, particularly for the chronically homeless[1] and homeless Veterans.

In August 2013, representatives from HUD, VA, and USICH attended one of these boot camps and heard this challenge:

> *Communities are not able to optimize the allocation of scarce housing resources to the most vulnerable homeless population due to difficulties sharing data or information between CoC and VA programs.*

In the current budget environment, communities cannot anticipate funding for new housing resources; therefore, communities need to develop systems to prioritize and target housing resources and connect households in need of assistance with the appropriate interventions. Therefore, it is important for communities to target the limited, intensive, and expensive permanent supportive housing resources (i.e., CoC Program, HUD-VA Supportive Housing (HUD-VASH)) to the people with the longest histories of homelessness and the most extensive needs. Research shows that these households are often the most frequent users of local emergency systems, including healthcare, and have the highest barriers to obtaining and maintaining permanent housing.

[1] See the proposed definition of "chronic homelessness" in the Emergency Solutions Grant Interim Rule at https://www.onecpd.info/resource/1927/hearth-esg-program-and-consolidated-plan-conforming-amendments (p. 75967).

It is critically important for homeless service providers to be able to share information about the homeless Veterans that each is serving to reach every homeless Veteran and to ensure that resources are used as effectively and efficiently as possible. CoCs use Homeless Management Information Systems (HMIS)—the information system designated by the CoC to comply with the HMIS requirements prescribed by HUD—to collect and report data on homeless persons, whereas VA uses the VA Homeless Management Evaluation System (HOMES). The use of separate systems makes data sharing a challenge specifically due to privacy concerns and technological incompatibilities.

> *"Target, engage, and don't let go until the Veteran is housed."* –Salt Lake City

With these considerations, HUD, VA, and USICH representatives developed their own 100-day goal to address this challenge:

> *The federal team will create guidance for communities on "what works"—best practices from communities that are currently sharing information locally between CoCs and VAMCs.*

To gather these best practices, HUD and VA convened a focus group with representatives from CoCs and VAMCs within four communities with local information sharing practices: Erie, PA; Phoenix/Maricopa County, AZ; Salt Lake County, UT; and Cincinnati, OH. These communities provided information regarding their individual communities' practices via an electronic survey, followed by a conference call in which they expanded on what has worked best across the communities. From this discussion and follow-up, best practices were identified as being implemented by these communities to meet the goals of ending Veteran homelessness by 2015.

The surveyed communities identified the three best practices in this document as ways to overcome barriers to information sharing across agencies and to prioritize Veterans for available housing resources.

- First, CoCs and VAMCs work together to create an inclusive list of Veterans experiencing homelessness in their communities.
- Second, standardized, prioritization instruments help to target housing interventions to those most in need.
- Third, navigators or guides assist each Veteran to attain and maintain housing.

Links to additional information about each practice are included as Appendix A.

Best Practice: Creating and Sharing a Community-Wide List of Veterans

A best practice that has been implemented within some communities is the generation of a list across agencies identifying homeless persons who are Veterans. The purpose of this list is to help agencies share client-level data by providing a prioritized list of clients, to target those individuals who are eligible for VA housing programs, and to serve those at greatest risk and often-greatest cost to the community by documenting additional characteristics such as chronic homelessness.

HMIS collects Veteran status and other criteria for each homeless household that could be used to prioritize housing, such as chronically homeless status (see HMIS specifications in Appendix B). VA serves many more Veterans beyond those experiencing homelessness but

> **Helpful Tool:** See Appendix B for HMIS specifications to generate a list of Veterans experiencing homelessness

screens for homelessness when serving Veterans at VAMCs, community-based clinics, or via outreach. This screening includes questions related to duration of homelessness. Therefore, VA staff in every community should also be able to generate information to help create such centralized, prioritized lists of Veterans experiencing chronic homelessness or other locally identified criteria.

Communication between stakeholders, especially between the local VAMC and CoC, is necessary to determine the homeless households to be included on the list of Veterans and the prioritized order in which they appear. Merging each stakeholder's list should yield a complete picture of Veterans meeting the identified criteria in a given community.

> In October 2012, the HMIS administrator of Salt Lake County pulled a list of homeless households who met the definition of Veteran and chronic homelessness, that, when compared to data generated from HOMES, as well as service provider lists, created a master list of approximately 220 homeless Veterans. Of that list, 90 were identified as possibly experiencing chronic homelessness and, upon further research, 50 were confirmed. Salt Lake County is using this prioritized list to end homelessness among those Veterans experiencing chronic homelessness in their community.

For the VAMC to participate in sharing information about a particular Veteran household, there must be a release of information (ROI) signed by the Veteran to allow information sharing between VAMCs and CoCs. The link to VA ROI Form 10-5345 is included in Appendix A for reference. Once ROIs are in place, VAMC staff can share information about those clients with the CoC to generate a master list of homeless Veterans. Similarly, HMIS have locally designed data sharing agreements and/or client consent forms that should be followed.

> **Helpful Tool:** See Appendix A for a link to VA's release of information form

> In Erie, Pennsylvania, VA asks clients to sign the ROI, prints out the HMIS Universal Data Elements, and faxes them to the HMIS Lead Agency for data input. In this situation, the master list of Veterans experiencing chronic homelessness is maintained and generated by the HMIS Lead Agency with client permission. This results in a more accurate list that the VAMC can use to determine whether someone is missing. VA can ask the Veteran to sign the ROI so the universal data elements can be sent to the HMIS Lead Agency. By having this centralized list, agencies in Erie have access to the same information, communication becomes clearer between stakeholders (VAMC and CoC), and communication becomes clearer between the service provider and the household experiencing homelessness.
>
> Erie reports that between October 1, 2012 and September 30, 2013, 169 households were identified as experiencing chronic homelessness, 19 of whom were also Veteran households. In September and October of 2013, 17 unique Veterans were added to the Erie HMIS from VA, one of whom is identified as experiencing chronic homelessness. By creating a community-wide list, Erie is able to target those individuals in need and direct them to the most appropriate services available.

Each community must decide who is ultimately responsible for creating and managing the prioritized list of Veterans. Generation of the list from HMIS would most likely be completed by the HMIS Lead Agency. Someone with HMIS access often merges or compares that document to interagency lists, particularly if the CoC already has the paperwork in place to allow sharing across programs and agencies and the client consent allows information to be shared.

Best Practice: Using a Tested, Validated Assessment to Prioritize and Target Interventions

Sharing data and information to create a centralized list is a critical step, but communities must also determine the systems they wish to use to prioritize and align interventions — and what data and information will need to be shared to support that prioritization. Communities can use an emerging number of instruments to prioritize people experiencing homelessness for housing. This document discusses the Vulnerability Index (VI), the Service Prioritization Decision Assistance Tool (SPDAT), and the combined VI-SPDAT. These assessments are in use among some of the communities who provided input for the development of this document. This document does not endorse these specific assessments and should not be construed as such an endorsement. Its purpose, rather, is to highlight the ways that these communities have used an assessment to guide resource targeting and initial screening processes. Links to these assessment tools and a resource to assess prioritization tools are available in Appendix A.

The VI, developed by Common Ground, is one of these tools to identify and prioritize people experiencing homelessness for housing. The survey uses research by Dr. Jim O'Connell of Boston's Health Care for the Homeless to measure the fragility of an individual's health, taking into account mortality risk factors and the duration of a person's homelessness. Some communities have already integrated the VI into their HMIS to prioritize those in need of housing.

> In Phoenix, the VI has been in use since 2010 with their Project H3 – Home, Health, and Hope. In April of that year, volunteers spread out over targeted areas of the region for 3 days and administered the VI to over 250 individuals with the goal to house the 50 most medically vulnerable. By November of the next year, 46 of the 50 had been housed.
>
> Following the success of the Project H3, the community has since launched Project H3 Vets implementing similar strategies focused on Veterans. At subsequent Stand Downs—events that bring together former members of the US Armed Forces experiencing homelessness and the myriad of services available to them—the community has implemented a Veteran survey, which incorporates the Vulnerability Index. As of the last Stand Down, Phoenix had identified 145 chronically homeless Veterans in need of housing.

The VI was combined with the pre-screening tool for the Service Prioritization Decision Assistance Tool (SPDAT) in 2013, creating the VI-SPDAT. The SPDAT is an intake, case management, and assessment tool designed to guide frontline workers and team leaders in an intensive case management approach to service delivery. This tool, designed by Iain DeJong of OrgCode Consulting, is being used by many communities as part of their coordinated assessment strategy. The SPDAT is intended to allow communities to triage and prioritize clients, helping to ensure that clients get the right housing intervention at the right time. Communities and funders can see evidence of change as a client is served in a project.

Some CoCs have worked with their HMIS administrators to implement the SPDAT in their software.

> Phoenix recognizes the role of the SPDAT, seeing it as an evidence-based tool that helps identify the most appropriate resource for the individual effectively and efficiently. As they implemented Stand Downs in their community, the number of chronically homeless Veterans increased from 141 in 2011 to 222 in 2012. After adopting the VI-SPDAT to target appropriate housing for the most at risk, the latest Stand Down showed a decrease in the number of chronically homeless Veterans to 145, with over 60 already housed, making their local goal of ending chronic homelessness for Veterans in 2014 within reach.

In July of 2013, a version of the SPDAT pre-screening form was released with the markers of heightened risk of morbidity (from the VI) incorporated into the tool. A VI-SPDAT is completed when a homeless individual or family is approached by street outreach (and provides consent) to understand their initial pressing issues and whether a full assessment is warranted. If needed, a full SPDAT assessment is completed, the homeless household is prioritized for housing based on the results, and the appropriate agency notifies them accordingly. Once a homeless household is prioritized, it is provided assistance to access and maintain housing. Further use of the SPDAT in regular intervals once the household has been housed allows staff to track improvements.

> Phoenix, building on their past success with the VI, is using this new pre-screening tool with a family provider, various human service agencies, and a mass shelter. The VI-SPDAT gives an immediate recommendation as to what type of housing option is most appropriate for the client—Permanent Supportive Housing, Transitional Housing, Rapid Re-housing, or none at this time—allowing the providers to assess need quickly.

Adopting an assessment for targeting interventions helps to remove barriers to information sharing by giving providers a common language for prioritizing how scarce resources are used. Assessments can also provide tangible incentives to share information—benefits that accrue to individual Veterans and to a community's homeless response systems when resources are properly targeted and prioritized.

Best Practice: Using Interagency Service Planning and Navigators to Address Individual Veterans' Needs

To enhance data and information sharing – and to use information to shape actions - another strong practice is to create an interagency group that meets regularly, as often as once a week, to discuss and create action plans for the Veterans on the list, review the options for housing that are currently available for homeless households, and follow up with those households who have been housed. Practically speaking, such real-time sharing of any personally identified information or service planning for individual Veterans requires appropriate client consent. Clear consent to share information, coupled with a forum for information sharing and planning, can produce important results for Veterans:

> *"The way out of homelessness is for someone to know my name and that someone to know their stuff."*
> -A formerly homeless Veteran

> Salt Lake County's group meets regularly, including the VAMC, emergency shelter staff, street/medical/library outreach teams, detox facilities, substance abuse treatment facilities, homeless medical care clinic, a mental health provider day center, and the Salt Lake City Police Department.

Other communities share the list of Veterans with groups that already meet. These groups can be at the local, county, or state level. Others use the centralized access point to direct homeless Veterans to HUD and VA programs serving Veterans.

> In Phoenix, a person identified as a navigator engages homeless households and guides them through the process of finding housing, assisting with whatever is necessary to make certain the Veteran experiencing chronic homelessness obtains and sustains housing. The position is funded through cooperation between the Arizona Department of Veteran Services and the Valley of the Sun United Way, and is staffed by Community Bridges, a

> behavioral health provider. The Navigator Program started with three navigators, three VAMC case managers, and one project coordinator in the same building. By having a designated navigator, first responders such as police officers, firefighters, and parks personnel know whom to call when they identify an individual in need of housing who claims to be a Veteran. The navigator can then work with the VAMC to determine eligibility quickly. With a navigator targeting Veterans experiencing chronic homelessness, valuable housing vouchers are more likely to be used by those with the greatest need for permanent supportive housing.
>
> A modified version of this process is being used in Salt Lake City where they follow the guideline, "Target, engage, and don't let go until the Veteran is housed." It is worth emphasizing that the navigator or guide works with the homeless household until housed, whether in VA housing or another community resource.

Navigators and interagency service planning can address obstacles to information sharing by creating knowledgeable and well-known points of contacts across systems with experience navigating distinct service systems and their information sharing requirements.

Conclusion

The communities using the prioritization instruments, generating and targeting housing to their list of homeless Veterans, and providing navigators or guides through the housing system are succeeding in ending homelessness for this population. The best practices presented here are helping communities share information, and in doing so, reducing the number of Veterans in the communities implementing them and will enable these communities to better realize the goal of ending Veteran homelessness by 2015.

Appendix A: Additional Resources

Find more information about the strategies discussed in this document at the links below.

HUD Policy Priorities

- Collaborating to Combat Homelessness among Veterans: https://www.onecpd.info/news/snaps-weekly-focus-collaborating-to-combat-homelessness-among-Veterans
- Why Coordinated Assessment is Critical to Ending Homelessness Locally: https://www.onecpd.info/news/snaps-weekly-focus-why-coordinated-assessment-is-critical-to-ending-homelessness-locally
- Giving Priority to Chronically Homeless Persons: https://www.onecpd.info/news/snaps-weekly-focus-giving-priority-to-chronically-homeless-persons

Examples of Prioritization Instruments

- *Coordinated Assessment: Understanding Assessment Tools*, National Alliance to End Homelessness: http://www.endhomelessness.org/library/type/webinar
- *The VI-SPDAT*, 100,000 Homes: http://100khomes.org/resources/the-vi-spdat
- *Vulnerability Index*, USICH: http://usich.gov/usich_resources/solutions/explore/vulnerability_index

Release of Information (ROI)

- VA Form 10-5345: http://www.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf

Navigator

- National League of Cities' Case Study on Phoenix: http://www.nlc.org/find-city-solutions/city-solutions-and-applied-research/housing-and-community-development/housing-rehabilitation-for-Veterans-with-disabilities/city-practices/community-wide-responses/phoenix
- "Phoenix's Most At-Risk Homeless Find Their Way, Thanks to a Team of 'Navigators,'" *Phoenix New Times*: http://www.phoenixnewtimes.com/2011-12-08/news/phoenix-s-most-at-risk-homeless-find-their-way-thanks-to-a-team-of-navigators/5

Appendix B: HMIS Specifications

This section provides guidelines for communities to generate a list of people experiencing homelessness that meet the definition of both Veteran and chronic homelessness. These specifications are needed for the HMIS Lead and vendor to generate the needed report. The specifications could be modified for other criteria used to prioritize housing, such as a prescreening score on an assessment tool, like the VI. The data elements required to generate this report are universal data elements, and should therefore be used by all programs.

Sample Report Layout

Chronically Homeless Veterans											
Name	Social Security Number	Date of Birth	Gender	Race	Ethnicity	First Program Entry Date	Current Program Name	Program Entry Date	Program Length of Stay		Length of Time Homeless in Past 5 Years
									Emergency Shelter	Street Outreach	

Programming Information

Program Type (APR Types)	Emergency Shelter, Street Outreach, Day Shelter	
Relevant Data Standards Fields (2010 Data Standards)		
Field Number	**Field Name**	**Relevant Data**
2.4	Program Name	
2.12	Method for Tracking Residential Occupancy	Bed night and Entry/Exit
3.1	Name	
3.2	Social Security Number	
3.3	Date of Birth	
3.4	Race	
3.5	Ethnicity	
3.6	Gender	
3.7	Veteran Status	Yes
3.12	Program Entry Date	
Universe of Clients		

Clients active in selected program(s) where:

[program_entry_date] <= [report_end_date]
and
([program_exit_date] is null)
and
([chronically homeless][1] = yes)
and
([ever been Veteran][2] = yes)

[1] Use data from the most recent program stay. Chronic homelessness should be calculated how your HMIS currently calculates chronic homelessness. HUD will publish standards for calculation after finalizing the 2013 Draft Data Standards.

[2] Use data from all programs with which the person has been involved and if ever identified as a Veteran show Veteran status as "yes."

Program stays from a shelter where bed nights are recorded must have an open record (intake without an exit) and at least one bed night used within 365 days of the end date of the report.

Program stays from an outreach program where contacts are recorded must have an open record with at least one contact reported within the last year.

1	**Filter:** All Street Outreach, Emergency Shelter (use Day Shelter as necessary)
2	**Filter:** Client universe
3	**Filter:** Veteran Status = yes (if ever identified as a Veteran in HMIS)
4	**Filter:** Chronic homelessness = yes (using whatever current methodology your HMIS uses to identify chronic homelessness)
5	Report **demographic** information using data from each client's last program stay.
6	**First Program Entry Date:** report the date of entry of the first emergency shelter or street outreach program record.
7	Report the **Current Program Name** and the **entry date** in which the client has an open record.

8	Report the current **Length of Stay** for each person:
	
	Emergency Shelter – Entry/Exit Shelters (Method 1)
	For shelters that use an entry/exit method of recording occupancy (person stays from entry to exit)
	IF [program exit date] < [report end date] THEN
	LOS = [program exit date] – [program entry date]
	
	Or
	
	IF ([program exit date] is null OR [program exit date] > [report end date] THEN
	LOS = [report end date] – [program entry date] + 1
	
	---------- 	
	
	Emergency Shelter – Bed Nights (Method 2)
	IF [date of last shelter stay] < [report end date] THEN
	LOS = [date of last shelter stay] – [date of first shelter stay]
	
	Or
	
	IF ([date of last shelter stay] is null OR [date of last shelter stay] > [report end date] THEN
	LOS = [report end date] – [date of first shelter stay] + 1
	
	Where there is more than a single shelter stay in a given report date range, each of the calculated bed nights should be summed together for the total bed nights.
	
	---------- 	

	Street Outreach
	IF [program exit date] < [report end date] THEN
	LOS = [program exit date] – [program entry date]
	
	Or
	
	IF ([program exit date] is null OR [program exit date] > [report end date] THEN
	LOS = [report end date] – [program entry date] + 1

9	**Length of time homeless in the past five years** equals the total of bed nights from a mass shelter plus length of stay in any other emergency shelter plus length of stay in outreach over the past five years including previous stays where the client was not chronically homeless. If a client is in multiple programs on a given night, count the client homeless only once for that night.

HCH-VA COLLABORATION QUICK GUIDE:

Joining Forces to Coordinate Care for Unstably Housed Veterans

JUNE 2013

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Why this guide?

The purpose of this quick guide is to assist Health Care for the Homeless (HCH) grantees with their efforts to establish and strengthen collaborations with local Veterans Affairs Medical Centers (VAMCs). Many HCH grantees are already collaborating with VAMCs to coordinate care for veterans and utilize the wealth of services, benefits, and expertise available from VAMCs, but there is room for improvement in these partnerships.

Who is this guide for?

This quick guide is useful for anyone working in an organization that serves veterans experiencing homelessness. Although it may be most applicable to the work of HCH administrators directly collaborating with VAMCs, this content is valuable for anyone interested in improving relationships with VAMCs, pursuing VA funding for veteran-specific services, and improving care coordination.

What does this guide include?

This quick guide discusses the federal goal to end veteran homelessness and how HCH grantees can contribute to this cause. There are sections on federal priorities for collaboration that involve community partners, the current state of HCH-VA partnerships, and promising practices for HCH-VA collaborations that are currently being utilized by some HCH grantees.

What can you expect to gain from this guide?

- You will be able to identify federal priorities for ending veteran homelessness that are related to collaborations with community partners.
- You will be able to describe the current state of collaborations between HCH grantees and VAMCs.
- You will be able to discuss examples of promising practices for collaboration with VAMCs.

Quick Guide Contents

Introduction

Significant strides have been made to achieve the federal goal of ending veteran homelessness in the United States by 2015, including a 17% decrease from 2009 to 2011.[1] However, with 62,619 veterans homeless on a single day in January 2012, reductions have not kept pace with the goal's aggressive annual benchmarks.[1] The Departments of Veterans Affairs (VA) and Housing and Urban Development (HUD) have been partners at the helm of this initiative, but their strategic priorities underscore the important role community partners can play in reducing veteran homelessness. VA Secretary Eric Shinseki even referred to community-based organizations as the "creative geniuses" of the movement to end veteran homelessness and attributed much of the success in reductions to these community-based partners.[4]

HRSA-supported Health Center Program grantees, specifically those with Health Care for the Homeless (HCH) funding, have much to contribute to this initiative, given their specialized knowledge and experience serving unstably housed veterans and the broader homeless population. Due to a breadth of sites nationally, HCH and other Health Center Program grantees serve as safety net providers for veterans in many communities.[6] In 2011, 249,548 veterans received services from Health Center Program grantees; of those veterans, 9% were homeless and received care from HCH grantees (Uniform Data System, 2011). Although it is often assumed that veterans access services primarily from VA Medical Centers (VAMCs), this is not always the case for a variety of reasons, including ineligibility, past negative experiences in the military or at the VAMC, and transportation barriers.[7] HRSA encourages all safety net providers to welcome veterans and their families into care and has created a Veteran's Hiring Initiative and other programs to help veterans and their families. Find out more at HRSA's Veterans Web Page.

90%

of HCH grantees are located within same county as a VA facility.

Given that HCH grantees provide services to unstably housed veterans, they already play an indirect role in the federal initiative to end veteran homelessness. However, the extent to which HCH grantees communicate and coordinate their efforts with local VAMCs has been unclear. In terms of geographic proximity, a study found that 90% of HCH grantees were located within the same county as a VA facility, demonstrating a prime opportunity for collaboration.[6] To further explore this issue, the National HCH Council surveyed HCH grantees in October 2012 regarding the veteran population they served and existing collaborations with local VAMCs.[1] According to the findings, the majority of HCH grantees (61%) had communicated with the local VAMC at least once, but the extent of communication and collaboration varied widely among communities. Indicating a desire for improved relations, 75% of survey participants identified relationship-building with VAMCs as their top training need.

To assist HCH grantees with their efforts to establish and improve collaborations with VAMCs, this quick guide will describe federal strategic priorities relating to collaboration with community partners, explore the current state of HCH-VA partnerships, and highlight promising practices for collaboration.

Federal Priorities for Collaboration

A collection of publications from federal agencies—including the Substance Abuse and Mental Health Services Administration (SAMHSA) and United States Interagency Council on Homelessness (USICH)—highlight key strategies to achieve the federal goal to end veteran homelessness. Many of these indicate the significant role of community partners in accomplishing these ends. HCH grantees represent an important group of community partners, given their experience working with veterans and the broader homeless

[1] You can access the full report on the veterans survey here: http://www.nhchc.org/wp-content/uploads/2013/02/Veterans-ReportFINAL_2-26-13.pdf

population. The items below synthesize key strategies and priorities identified by SAMHSA and USICH that could influence and inspire the collaborative efforts of HCH grantees

Promote Collaborative Leadership

Objective 1 of USICH's *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness 2010* is to promote collaborative leadership.[8] This strategy recommends that local communities "break down the silos" to organize federal, state, and local resources with the efforts of community partners to enhance coordination and effectiveness. Coordinated plans should be driven by local conditions, not a one-size-fits-all approach. *Opening Doors* cites collaborative efforts to end veteran homelessness as the signature initiative demonstrating Objective 1. Specific strategies that could be adopted by HCH grantees and local VAMCs include: testing, modeling, and learning more about interagency collaboration and reviewing budget processes to determine avenues for recognizing savings across partners.

Collaborative Strategies to Reduce Veteran Homelessness:

- Promote collaborative leadership
- Communication and integration of services across communities
- Role of community-based organizations
- Need for education, outreach, and awareness of available programs

Communication and Integration of Services across Communities

The importance of communicating and integrating services across communities was noted in USICH's report on *Positive Outliers: Communities on Track to End Homelessness among Veterans*.[5] This theme was identified in all five communities on track to end veteran homelessness by 2015 that were profiled in the report. Typically, integration involved Continuum of Care providers, VA programs, and the local Public Housing Authority. However, HCH grantees could be natural partners in this service integration, if they are not already. The sharing of data and reports among agencies was identified as another theme among positive outlier communities and also noted as a guiding principle by a SAMHSA expert panel on veteran homelessness.[5, 9] The positive outlier report noted: "This collaboration also created a better way to overcome the different eligibility requirements of each sector so that all veterans (whether they receive VA benefits or not) could access services to leave homelessness" (p. 2).[5] HCH grantees offer an important alternative for care to veterans who are either not eligible for VA services, have not yet obtained VA medical benefits, or are uncomfortable accessing VA services due to past negative experiences at VAMCs or in the military.

Role of Community-Based Organizations

Although many strategic priorities focus on interagency collaboration among federal partners, the role of community-based organizations, including HCH grantees, is also highlighted. A USICH report identified the collaboration across agencies to address veterans' needs not provided through VA programs as one of three necessary components for ending veteran homelessness.[10] HCH grantees provide services to a substantial number of unstably housed veterans, some of whom are ineligible for VA services or choose not to access them. Others simply need assistance navigating the application process and accessing VA services. HCH grantees and other community-based organizations are critical to fulfilling unmet needs and providing linkage to VAMCs. The VA supports the services of community-based organizations through 4,000 interagency collaboration agreements with community service providers.[11] Contracting with community-based organizations allows the VA to enlist the services of those more experienced in serving the

homeless population. Methods for contracting with the VA will be discussed in the promising practices section. USICH analysis of a SAMHSA expert panel on veteran homelessness noted that community-based organizations will need additional skills and knowledge, namely military cultural competence, to enhance and tailor their provision of services for veterans.[9]

Need for Education, Outreach, and Awareness of Available Programs

The VA, HUD, and other federal agencies offer a wealth of programs and benefits for veterans, including medical benefits, HUD-VASH housing vouchers and supportive services, disability and pension benefits, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), to name a few. However, SAMHSA's expert panel on veteran homelessness emphasized the need to reach out to veterans and their families to publicize available programs.[9] Because HCH grantees are sometimes the first provider veterans turn to for services, they have the opportunity to raise awareness of other available programs and benefits, assist with applications, facilitate referrals, and help veterans navigate VAMC systems of care. Many HCH grantees are already increasing awareness and linkage by making referrals to VAMCs, participating in the HUD-VASH program, assisting with discharge status upgrade applications, helping veterans understand and apply for VA benefits, and assisting with GI Bill education applications.[7]

Current State of HCH-VA Partnerships

According to the National HCH Council's October 2012 survey, 61% of HCH grantees had communicated with local VAMCs at least once, and half of these grantees (50%) communicated on an occasional basis. Lines of communication with VAMCs were initiated in numerous ways, with the three most common being participation in Stand Down events (19%), making one strong VAMC contact and building a relationship around it (14%), and physician-to-physician communication (12%). Qualitative responses showed additional ways they initiated communication, including the region's Veterans Integrated Service Network (VISN) putting pressure on the VAMC to get involved with community partners, the HCH grantee doing administrative outreach to the VAMC, serving as client advocates for those eligible for VAMC services, participating in a local homeless collaborative group with the VAMC, and having staff that are military veterans and linked in to the VAMC.

16%

of HCH grantees that had communicated with VAMC reported no collaboration.

Of those grantees that had communicated with VAMCs, nearly 16% reported no collaboration with them. For those grantees that did collaborate, the most common types of collaboration were making referrals to VAMCs (39%) and receiving referrals from VAMCs (12%). A small number of grantees (<10% each) reported that they received reimbursement through the VA's Grant and Per Diem Program, had inter-agency agreements with VAMCs, had VAMC outreach workers come to their health centers, performed joint outreach with VAMC staff, co-located services with VAMCs, or attended cross-training that involved VAMCs. Through qualitative responses, participants identified additional ways they collaborated with VAMCs, including having bi-weekly meetings, having HCH case managers communicate with VA personnel, contracting with the VA for detox services, and establishing a relationship with the VAMC for resource sharing and partnering outreach services.

10%

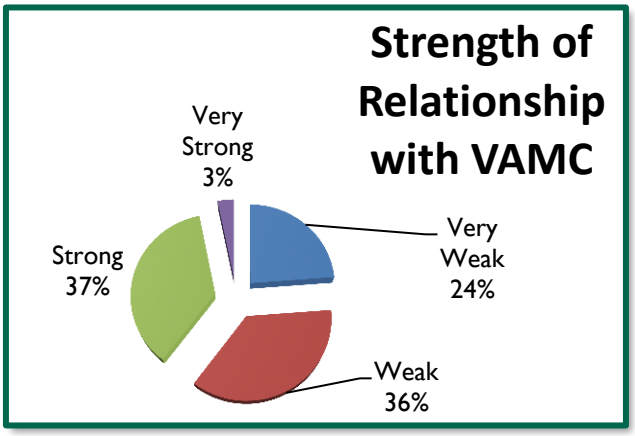
of HCH grantees received reimbursement from VA or another source for serving veterans.

Only 10% of HCH grantees reported receiving reimbursement from the VA or another source to provide services to veterans, while 76% said they did not and 14% were unsure. Grantees that did receive reimbursement were asked to identify the source(s) in an open-ended question. Respondents reported that reimbursement was received through contracting with the VA to provide specific services (e.g., detox services, dental services), participating

in the VA's Grant and Per Diem Program, and receiving a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to provide outreach to veterans. Those that did not receive reimbursement were asked to rate how much the cost of serving veterans impacted their health center's financial resources. Respondents reported a rating average of 2.04[2], indicating that serving veterans slightly impacted financial resources.

When asked to rate the strength of their relationships with local VAMCs, participants reported a rating average of 2.19[3]. This indicated that their relationships with local VAMCs were perceived to be somewhat weak (36%), although 37% reported that their relationships were strong and 3% reported that their relationships were very strong.

Grantees reported several factors that facilitated their working relationships with local VAMCs. The most frequently reported factors included the assistance of VA outreach workers and case managers (22%) and gaining better contact information of VAMC staff (16%). Some respondents (16%) reported that no factors facilitated their working relationships. In terms of barriers to their working relationships with local VAMCs, 21% reported the insular or isolated culture of VAMCs and 20% reported communication issues. Meanwhile, 24% reported that no factors were barriers to their working relationships.



Promising Practices for HCH-VA Collaborations

As the survey findings demonstrated, many HCH grantees are already partnering with local VAMCs to coordinate care for veterans. However, some have had more success building mutually beneficial relationships than others. For those grantees looking to create or improve upon their VAMC partnerships, the following promising practices could be considered as starting points. For additional promising practices, visit the USICH's Explore the Solutions Database and search "veterans."

Streamline Referral Process to and from VAMC

According to survey findings, making referrals to VAMCs was the most common form of collaboration among HCH grantees, followed by receiving referrals from VAMCs. Due to the frequency of these activities, it is important that the process be streamlined, seamless, and effective. To facilitate the referral process, the Health Resources and Services Administration (HRSA) recommends that HCH grantees use the VA Facility Locator and Directory to find the nearest VAMC and help veterans complete the VA FORM 10-10EZ to apply for medical benefits if they have not already done so (http://www.hrsa.gov/veterans/). Each VAMC has a homeless coordinator, who can serve as the point-person for referrals on the VA end. Establishing a relationship with the homeless coordinator—including the sharing of available HCH services, hours, sites, and contact information—could help generate new referrals to HCH grantees and improve the ease of referrals to the VAMC. Like all referrals, there can be struggles to ensure success, including missed appointments, miscommunication, and transportation barriers. HCH grantees should consider these issues proactively to make necessary accommodations.

[2] On a scale of 1=not at all, 2=slightly, 3=moderately, 4=significantly.
[3] On a scale of 1=very weak, 2=weak, 3=strong, 4=very strong.

Establish Formal Interagency Agreement with VAMC

According to our survey, just 3% of HCH grantees have interagency agreements with local VAMCs. Formalizing existing or future collaborations through interagency agreements can facilitate a mutually beneficial relationship in which expectations and responsibilities of all partners are well-established. One strong example of a formal interagency agreement is the collaboration between Terry Reilly Health Services (Southwest Idaho), an HCH grantee, and the local VAMC. The VAMC expressed interest in providing its medical residents with a community-based education opportunity to serve an underserved population. Through the VA's collaboration with Terry Reilly, an internal medicine clinic was established to increase specialty access for Terry Reilly patients while jointly providing health professional education.VA faculty supervise the clinic, which is staffed by internal medicine physicians, internal medicine residents, and University of Washington medical students. There are minimal costs associated with the operations of the internal medicine clinic, as residents and medical students volunteer their services and VA faculty receive minimum wage pay as Terry Reilly employees so they are covered under the Federal Tort Claims Act (FTCA). The clinic is available to all Terry Reilly patients, and 4% of patients are veterans. Although this model of interagency agreement is specific to internal medicine and health professional education, the general approach of establishing a formal interagency agreement is replicable more broadly to meet the mutual needs of HCH grantees and VAMCs.

Pursue VA Funding for Veteran-Specific Services

According to survey findings, only 10% of HCH grantees receive some form of reimbursement from the VA or elsewhere for providing services to veterans. However, there are numerous opportunities for community-based organizations to contract with VAMCs, including as Community-Based Outpatient Clinics (CBOCs), the Supportive Services for Veteran Families Program (SSVF), the VA Homeless Providers Grant and Per Diem Program (GPD), and the HUD-VA Supportive Housing program (HUD-VASH). The CBOC program allows local non-profits to contract with the VA to provide specific services to a defined group of unstably housed veterans, a pursuit encouraged by HRSA (http://www.hrsa.gov/veterans/). To find CBOC contracting opportunities, visit https://www.fbo.gov/ and search "CBOC." Another avenue for funding is the SSVF program, which awards non-profit organizations with grants to provide supportive services to very low-income veteran families living in or transitioning to permanent housing. Supportive services can include health care, daily living, personal financial planning, transportation, fiduciary and payee, legal, child care, and housing counseling services. The GPD program funds community agencies providing services to unstably housed veterans that promote residential stability, increase in skill levels and/or income, and greater self-determination. Programs that provide either supportive housing and/or supportive services such as case management, crisis intervention, and counseling are eligible. Five percent of HCH grantees reported that they received GPD funding. Finally, the HUD-VASH program is a joint effort between HUD and the VA to provide unstably housed veterans with Housing Choice Voucher (HCV) rental assistance, case management, and clinical and supportive services. VAMCs may contract with or provide linkage to community-based organizations for assistance with supportive services. A few HCH grantees reported participation in HUD-VASH in the National HCH Council survey. For more information on funding sources for organizations serving unstably housed veterans, the National Resource Directory provides a listing of grant opportunities for homeless service providers.

Connect Veterans with Mainstream Benefits outside VA System

For those veterans who are either ineligible for VA benefits and services due to discharge status or length of service, or choose not to access the VA due to past negative experiences in the military or at VAMCs, there are still other avenues to pursue federal benefits. Even for veterans who qualify for VA benefits, this can be supplemented by other mainstream benefits. The expansion of Medicaid eligibility could benefit the 535,000 uninsured veterans who have incomes below 138% of the federal poverty level, although outreach and enrollment efforts will be required to maximize utilization.[2] SAMHSA's SSI/SSDI Outreach, Access, and Recovery program (SOAR) can be utilized to increase access to SSI/SSDI disability income benefits, Medicaid, and/or Medicare for adults who are homeless or at risk of homelessness and have a mental illness and/or a co-occurring substance use disorder. SOAR provides a curriculum to train direct service staff on how to improve and expedite the SSI/SSDI application process and avoid appeals. Typically, 10-15% of persons who are homeless and apply for SSI/SSDI with no assistance are approved on initial application, but those communities utilizing the SOAR approach achieve approval ratings of 71% in 3 months.[3] The use of SOAR was cited in USICH's *Positive Outliers* report as a means of bridging service gaps in the VA system with mainstream benefits.[5] Some HCH grantees have also integrated SOAR into their programs by training direct service staff and providing consumers, including unstably housed veterans, with thorough assistance navigating the application process. SAMHSA's SOAR Technical Assistance Center provides further information on how to integrate SOAR into your community.

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Evaluation

The National HCH Council is continually engaging in quality improvement of all of our products. This publication was developed with the intent to have an impact on your work. Please complete the evaluation at https://www.surveymonkey.com/s/HCH-VA_QkGuide to provide feedback on the quality and usefulness of this document.

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United States Interagency Council on Homelessness

Preventing and Ending Homelessness in the United States

The Housing First Checklist: A Practical Tool for Assessing Housing First in Practice

Introduction

Housing First is a proven method of ending all types of homelessness and is the most effective approach to ending chronic homelessness. Housing First offers individuals and families experiencing homelessness immediate access to permanent affordable or supportive housing. Without clinical prerequisites like completion of a course of treatment or evidence of sobriety and with a low-threshold for entry, Housing First yields higher housing retention rates, lower returns to homelessness, and significant reductions in the use of crisis service and institutions.[1] Due its high degree of success, Housing First is identified as a core strategy for ending homelessness in *Opening Doors: the Federal Strategic Plan to End Homelessness* and has become widely adopted by national and community-based organizations as a best practice for solving homelessness.

Housing First permanent supportive housing models are typically designed for individuals or families who have complex service needs, who are often turned away from other affordable housing settings, and/or who are least likely to be able to proactively seek and obtain housing on their own. Housing First approaches also include rapid re-housing which provides quick access to permanent housing through interim rental assistance and supportive services on a time-limited basis. The approach has also evolved to encompass a community-level orientation to ending homelessness in which barriers to housing entry are removed and efforts are in place to prioritize the most vulnerable and high-need people for housing assistance.

As Housing First approaches become adopted more widely, the need for clarity increases around what the Housing First approach entails and how to know whether a particular housing program or community approach is truly using a Housing First approach. Robust tools and instruments are available which can quantitatively assess and measure a housing program's fidelity to Housing First, and recent research has attempted to rigorously evaluate Housing First implementation.[2] For quick screening, policymakers and practitioners will benefit from this practical, easy to use guide to identify and assess the implementation of the core components of the Housing First approach.

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How to Use this Tool

This user-friendly tool is intended for use by policymakers, government officials, and practitioners alike to help make a basic assessment of whether and to what degree a particular housing program is employing a Housing First approach. The tool can be used as a checklist that can be reviewed during a site visit, program audit, or program interview, or as a guide and checklist when reviewing funding applications or reviewing a program's policies and procedures.

The tool is organized in two sections. The first section is a checklist of the core and additional elements of Housing First at the housing program or project level. The second section is a checklist of elements of Housing First at the community-level. Users of this tool should be aware that this tool assesses Housing First adoption along a spectrum, rather than as a simple *yes/no* or *pass/fail*. This tool is also not intended to serve as or supplant a more comprehensive housing and program quality assessment tool, but may supplement or be used in conjunction with such tools.

Quick Screen: Is permanent supportive housing Housing First?

1. *Are applicants required to have income prior to admission?*
2. *Are applicants required to be "clean and sober" or "treatment compliant" prior to admission?*
3. *Are tenants able to be evicted for not following through on their services and/or treatment plan?*

If the answer is "Yes" to any of these questions, the program is not Housing First.

Housing First at the Program/Project Level

Core Elements:

- ❑ Admission/tenant screening and selection practices promote the acceptance of applicants regardless of their sobriety or use of substances, completion of treatment, and participation in services.
- ❑ Applicants are seldom rejected on the basis of poor credit or financial history, poor or lack of rental history, minor criminal convictions, or behaviors that indicate a lack of "housing readiness."
- ❑ Housing accepts referrals directly from shelters, street outreach, drop-in centers, and other parts of crisis response system frequented by vulnerable people experiencing homelessness.
- ❑ Supportive services emphasize engagement and problem-solving over therapeutic goals. Services plans are highly tenant-driven without predetermined goals. Participation in services or program compliance is not a condition of permanent supportive housing tenancy. Rapid re-housing programs may require case management as condition of receiving rental assistance.
- ❑ Use of alcohol or drugs in and of itself (without other lease violations) is not considered a reason for eviction.

Additional Elements Found in Advanced Models:

- ❑ Tenant selection plan for permanent supportive housing includes a prioritization of eligible tenants based on criteria other than "first come/first serve" such as duration/chronicity of homelessness, vulnerability, or high utilization of crisis services.
- ❑ Tenants in permanent supportive housing given reasonable flexibility in paying their tenant share of rent (after subsidy) on time and offered special payment arrangements (e.g. a payment plan) for rent arrears and/or assistance with financial management (including representative payee arrangements).

- ❑ Case managers/service coordinators are trained in and actively employ evidence-based practices for client/tenant engagement such as motivational interviewing and client-centered counseling.

- ❑ Services are informed by a harm reduction philosophy that recognizes that drug and alcohol use and addiction are a part of tenants' lives, where tenants are engaged in non-judgmental communication regarding drug and alcohol use, and where tenants are offered education regarding how to avoid risky behaviors and engage in safer practices.

- ❑ Building and apartment unit may include special physical features that accommodate disabilities, reduce harm, and promote health among tenants. These may include elevators, stove-tops with automatic shut-offs, wall-mounted emergency pull-cords, ADA wheelchair compliant showers, etc.

Housing First at the Community Level

- ❑ Emergency shelter, street outreach providers, and other parts of crisis response system are aligned with Housing First and recognize their roles to encompass housing advocacy and rapid connection to permanent housing. Staff in crisis response system services believes that all people experiencing homelessness are housing ready.

- ❑ Strong and direct referral linkages and relationships exist between crisis response system (emergency shelters, street outreach, etc.) and rapid re-housing and permanent supportive housing. Crisis response providers are aware and trained in how to assist people experiencing homelessness to apply for and obtain permanent housing.

- ❑ Community has a unified, streamlined, and user-friendly community-wide process for applying for rapid re-housing, permanent supportive housing and/or other housing interventions.

- ❑ Community has a coordinated assessment system for matching people experiencing homelessness to the most appropriate housing and services, and where individuals experiencing chronic homelessness and extremely high need families are matched to permanent supportive housing/Housing First.

- ❑ Community has a data-driven approach to prioritizing highest need cases for housing assistance whether through analysis of lengths of stay in Homeless Management Information Systems, vulnerability indices, or data on utilization of crisis services.

- ❑ Policymakers, funders, and providers collaboratively conduct planning and raise and align resources to increase the availability of affordable and supportive housing and to ensure that a range of affordable and supportive housing options and models are available to maximize housing choice among people experiencing homelessness.

- ❑ Policies and regulations related to permanent supportive housing, social and health services, benefit and entitlement programs, and other essential services support and do not inhibit the implementation of the Housing First approach. For instance, eligibility and screening policies for benefit and entitlement programs or housing do not require the completion of treatment or achievement of sobriety as a prerequisite.

- ❑ Every effort is made to offer a transfer to a tenant from one housing situation to another, if a tenancy is in jeopardy. Whenever possible, eviction back into homelessness is avoided.

CREATING EFFECTIVE SYSTEMS TO END HOMELESSNESS

A Guide to Reallocating Funds in the CoC Program

September 2014

CREATING EFFECTIVE SYSTEMS TO END HOMELESSNESS:
A GUIDE TO REALLOCATING FUNDS IN THE COC PROGRAM

Purpose of the Tool

This guide provides Continuums of Care (CoCs) and recipients of CoC Program funds with information on reallocation and strategies for undertaking reallocation through the annual CoC Program Competition. This tool can help CoCs:

- Make decisions about when reallocating funds is necessary;
- Understand the different types of reallocation and in what circumstances they are appropriate; and
- Navigate and overcome challenges in the reallocation process.

This tool is not intended to provide technical information or guidance on how to develop an effective application for a reallocated project under a specific CoC Program Competition. It is not specific to any particular competition year. HUD will issue instructions and guidance related to the actual application process and make them available at www.onecpd.info.

What's in this tool?

This tool is divided into five sections:

- Section 1 provides general information on what reallocation means and under what circumstances CoCs should consider reallocating CoC Program funds.

- Section 2 discusses how to make decisions about which projects should be reallocated, and includes information on the strategic planning and project assessments that can guide these decisions.

- Section 3 discusses reallocations at a project- and grant-level, explaining the different types of reallocations along with illustrative examples. This section also discusses some of the unique challenges associated with 'one-to-one same provider' reallocations, sometimes referred to as 'conversions'.

- Section 4 includes case studies of three communities who used reallocations to create more effective systems to end homelessness.

- Section 5 includes a list of useful additional resources around strategic planning, project assessments, and the reallocation process.

SECTION 1: UNDERSTANDING REALLOCATIONS

What is Reallocation?

Reallocation refers to the process by which a CoC shifts funds in whole or in part from existing CoC-funded projects that are eligible for renewal to create one or more new projects. CoCs can pursue reallocations through the annual CoC Program Competition. A reallocated project must be a new project that serves new participants and has either a rapid re-housing or permanent supportive housing program design. A new reallocated project may use resources from an existing project, including staff, but it is not simply a continuation of an existing project that serves existing participants.

When Should a CoC Reallocate?

Reallocating funds is one of the most important tools by which CoCs can make strategic improvements to their homelessness system. Through reallocation, CoCs can create new, evidence-informed projects by eliminating projects that are underperforming or are more appropriately funded from other sources. Reallocation is particularly important when new resources are scarce.

Decisions regarding reallocation are best made when guided by an overall strategic plan, in which the CoC assesses existing projects for their performance and effectiveness in ending homelessness. In general, CoCs should direct funding towards projects that:

a. Serve the highest need individuals or families;
b. Help project participants obtain permanent housing as rapidly and directly from homelessness as possible;
c. Ensure long-term housing stability; and
d. Ensure the best and most cost-effective fit given a community's needs.

CoCs should strive to match their inventory of projects to the needs of people experiencing homelessness within the CoC. For instance, a CoC may find that the majority of existing projects serve lower-barrier households but that they cannot meet the needs of individuals and families experiencing chronic homelessness. Through reallocation, the CoC can correct this imbalance in their inventory to ensure that they have adequate capacity to serve the people experiencing homelessness in their community.

The reallocation process specifically applies to projects funded through HUD's CoC program. However, communities should assess all of the projects in their inventory, regardless of how they are funded, and decide which ones are most needed and which ones should be shifted to other purposes.

What types of projects can be reallocated?

CoCs can reallocate funding from any project eligible for renewal in a competition year. The annual CoC Program Competition Notice of Funding Availability (NOFA) dictates what types of projects may be created through reallocation in a given competition. For example, the FY 2013-FY 2014 CoC Program Competition NOFA limited the types of new projects that could be created through reallocation to:

a. New permanent supportive housing for people experiencing chronic homelessness; and
b. Rapid re-housing to serve households with children coming from the streets or an emergency shelter.

When Can a CoC Reallocate?
Reallocation is one way that CoCs can shift resources; however, CoC-funded projects can make limited changes to their projects without reallocating by receiving a grant amendment. A grant agreement cannot, however, change the entire scope of a project. Here are examples of changes to CoC-funded projects that can and cannot be made through grant amendments.

Can be made through grant amendment	**Cannot** be made through grant amendment
A permanent supportive program housing wishes to shift funds within its existing grant from services costs to rental assistance costs in order to create additional units	Component changes, such as if a transitional housing project wanted to change to permanent supportive housing
If a transitional housing project wants to reduce the average length of time households are in their programs, they can do so without reallocating	Major population changes, such as if a project wanted to change from serving families with children to serving individuals experiencing chronic homelessness

In some cases, a CoC may wish to significantly change an existing project's model (component) or population, while keeping the same provider organization or building/housing units. Although the CoC may view this simply as changing or converting an existing program, HUD treats this as the creation of a new reallocated project and not a continuation of an existing effort. Funds awarded to a new reallocated project typically cannot serve the same households that were assisted under the former renewal project and the recipient of funds for the new project cannot incur costs until the new grant agreement has been executed by HUD.

Different types of reallocation
There is no cookie cutter approach to reallocation. Although HUD may limit what types of new projects may be created with reallocated funds, it does not dictate to CoCs what types of renewal projects can be reallocated or how that process should occur.

There are many combinations of funding for projects that can be involved in a reallocation. Examples include:

- Funding from one project (or partial funding from one project) can be reallocated into a new project operated by the same provider;
- Funding from one project (or partial funding from one project) can be reallocated into a new project operated by a different provider;
- Funding from one project (or partial funding from one project) can be reallocated into many new projects;
- Funding from many projects (or partial funding from many projects) can be reallocated into one new project; and
- Funding from many projects (or partial funding from many projects) can be reallocated into many new projects.

The type of reallocations a CoC should pursue in a single competition depends on the CoC's individual circumstances. While reallocation can be complicated and does not come without risk, it is a necessary part of ensuring that a CoC's homeless assistance system meets the needs of people experiencing

homelessness. Reallocations can only occur through the annual CoC Program competition. CoCs should not wait to make reallocation decisions only during the competition. Instead, CoCs' decisions regarding what to reallocate should be guided by the CoC's multi-year strategic plan.

SECTION 2: MAKING DECISIONS ABOUT WHAT TO REALLOCATE THROUGH STRATEGIC PLANNING

CoCs should base decisions about reallocation on a thorough analysis of the needs and gaps in housing and services in their community. CoCs should also be thinking through how best to use the funding sources available to them. They should conduct this analysis on a regular basis. Although the type of projects that can be created through reallocation may change from one CoC Program Competition NOFA to the next, the process will always emphasize a strategic analysis of whether existing projects are meeting the needs of people experiencing homelessness and what new projects are needed. While reallocation in the context of this tool only applies to CoC Program-funded projects, the CoC should take into consideration all housing and services available when doing strategic planning to make decisions that will allow for all funding sources and resources to be used as effectively and efficiently as possible.

Following are some examples of the strategic analysis and planning that are needed to inform reallocation decisions.

Assessing Need by Population

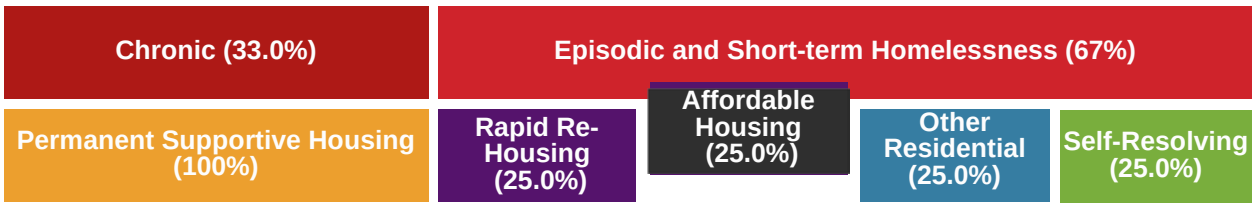
The best way to assess need is to thoroughly review the populations experiencing homelessness and identify the types and amount of interventions needed. The first step is to create a population breakdown showing how many people in various population categories experience homelessness over the course of a year. At a minimum, the breakdown should include the following categories:

- Unaccompanied adults
- Unaccompanied adults experiencing chronic homelessness
- Unaccompanied underage youth (under 18)
- Unaccompanied transition-aged youth (18-24)
- Families with children
- Families with children experiencing chronic homelessness
- Veterans
- People fleeing domestic violence

These categories overlap, which should be taken into consideration when conducting this analysis.

The need for shelter, rapid re-housing, affordable housing, transitional housing, permanent supportive housing, and other affordable housing options should be assessed for each population, although in some cases categories can be combined. At this stage, the analysis should only consider the type of intervention needed by people experiencing homelessness and not eligibility requirements for specific programs, which can be addressed later.

Chart Showing Department of Veterans' Affairs Nature of Homelessness and Interventions Needed to Achieve Permanent Housing



There are several examples of models that communities can draw from to help determine their need for different forms of assistance. For example, to support their effort to end Veteran homelessness by 2015, the Department of Veterans' Affairs (VA) has developed a model (see chart above) assessing need where one third of Veterans experiencing homelessness over the course of a year experience chronic homelessness and the solution for them is permanent supportive housing. The VA has also determined that for the remaining 67 percent of Veterans who experience episodic and short-term homelessness, rapid re-housing, affordable housing, and other residential programs are the appropriate interventions, except in those cases where the Veterans are able to resolve their own homelessness without assistance. While this analysis is specific to Veterans experiencing homelessness and only programs funded through the VA, it is an example of how this type of analysis can help in a strategic-planning process.

The Road Home, a major homeless assistance provider for families experiencing homelessness in Salt Lake City, has conducted a strategic analysis of its programs in order to determine how best to serve these families. Rapid re-housing is the most common intervention, although some households with higher needs and barriers receive longer term assistance, including permanent supportive housing. The key the Road Home's analysis is using data from the CoCs Point-in-Time (PIT) count and HMIS to understand the nature of homelessness within the CoC, and the extent to which each of the populations listed above are represented. CoCs should use this information to determine which types of households it will prioritize for the most intensive interventions and which households will receive limited assistance when there are not enough resources available.

Assessing Need by Program Type

In addition to looking at their homeless populations, CoCs should analyze their stock of housing and services and determine whether they meet the needs of people experiencing homelessness. This analysis will help the CoC to determine where there are gaps and whether there may be too much of a single intervention (e.g., transitional housing). This will help guide the CoC's decisions about whether or not to reallocate and begin the process of identifying which projects to eliminate or reduce. Here are some examples of how to assess whether your community needs more shelter, rapid re-housing, transitional housing, and/or permanent supportive housing.

Assessing the Need for Shelter

The need for shelter depends on several factors, including the average length of homeless episodes. If data shows that people are sleeping unsheltered, shelters are at full capacity, and average stays in shelter are brief (less than 30 days), that almost certainly indicates a need for greater shelter capacity. On the other hand, if people are sleeping unsheltered while there is available shelter capacity, shelter providers should evaluate their shelter policies and conditions within their shelters and make

Affordable Housing

For most individuals and families, homelessness is caused by the gap between their income and the cost of housing in their community. More affordable housing options are needed for people with extremely low-incomes who are experiencing or at risk of homelessness. While affordable housing without services is not an eligible program type under the CoC Program, it is nevertheless a necessary tool for ending homelessness. HUD and USICH encourage CoCs to coordinate with local Public Housing Authorities (PHAs) and owners of housing assisted through HUD's Multifamily programs to increase affordable housing opportunities for people experiencing homelessness. To learn more about strengthening collaboration with PHAs, visit USICH's PHA Guidebook at http://usich.gov/usich_resources/pha_portal and http://portal.hud.gov/hudportal/documents/huddoc?id=pih2013-15.pdf. For more information on how owners of Multifamily housing can assist people experiencing homelessness, go to http://portal.hud.gov/hudportal/documents/huddoc?id=13-21hsgn.pdf.

improvements—not add additional shelter capacity. Finally, when average shelter stays are more than 30 days, it is an indication that other interventions such as rapid re-housing are needed –not additional shelter capacity.

Many people experiencing homelessness do not need any assistance beyond emergency shelter. In many communities, this figure ranges from 10 to 50 percent. This figure can be estimated by looking at the percentage of people who exit homelessness within a very short period of time (e.g., two weeks) without any assistance beyond emergency shelter.

Assessing the Need for Rapid Re-Housing

Although rapid re-housing is a relatively new intervention, it has become widely recognized as a promising practice for many households experiencing homelessness, particularly those who have less intensive service needs. The primary indicator that a CoC needs more rapid re-housing assistance is if there are a high number of families who do not have significant service needs but who experience homelessness for typically more than 30 days. Although many communities reserve rapid re-housing for households with certain characteristics (e.g. first time experiencing homelessness, people with sufficient income), evidence gathered to date does not support limiting rapid re-housing based on these characteristics. While it can be used to serve both individuals and families, communities that have shown great progress towards reducing homelessness among families have done so by using rapid re-housing for more than half of all families experiencing homelessness served within the community.

Assessing the Need for Transitional Housing

Transitional housing is funded by a variety of Federal, State, local, and private funding sources and can be implemented in a number of different models, including crisis housing, interim housing, and transition-in-place housing. However, HUD's transitional housing program generally has served the function of longer-term housing with supportive services that can be provided for up to 24-months. While many people who have been assisted in long-term transitional housing could be served more efficiently in other program models, there is a case to be made that this model may be appropriate for some people. These include:

- Certain individuals and parents with children struggling with a substance use disorder or in early recovery who desire more intensive support to achieve their recovery goals;
- Survivors of domestic violence or other forms of severe trauma who feel unsafe or unprepared to live on their own in the community; and
- Underage and transition-age (16-24) unaccompanied youth (including pregnant and parenting youth) who feel unprepared or are legally unable to live independently.

Assessing the Need for Permanent Supportive Housing

Permanent supportive housing is generally most appropriate for people experiencing chronic homelessness and those who are most at risk of becoming chronically homeless without this level of support (i.e. people with disabling or chronic conditions who need long-term services and supports to achieve housing stability). The need for permanent supportive housing should be assessed separately for unaccompanied individuals and families. If existing permanent supportive housing exclusively or mostly serves people who experienced chronic homelessness and if there are still many people experiencing chronic homelessness within the CoC, there is a need for more permanent supportive housing. If the existing permanent supportive housing programs are not serving people who have experienced chronic homelessness, CoCs should adopt a policy that prioritizes people experiencing chronic homelessness in permanent supportive housing units that turnover. If the number of people experiencing chronic homelessness or at risk of becoming chronically homeless has been reduced in the community, this may indicate a lower need for permanent supportive housing.

More information about prioritizing people for permanent supportive housing can be found in HUD's chronic homelessness prioritization notice.

Performance and Outcome Analysis

Another factor to consider is the performance of existing programs and their contribution to meeting your community's goals. The process for doing so involves establishing outcome measures for homelessness programs that are connected to the community's overall goals. These outcome measures should allow for cross-program comparisons. The following are a few examples of helpful outcome measures:

- The average length of time between when program participants enter the program and when they move into permanent housing;
- The percentage of program participants who are in permanent housing when they exit the program;
- The percentage of program participants who have a subsequent episode of homelessness after moving to permanent housing within 6 months;
- The average level of barriers to housing for people served by the program; and
- The average cost of the program per positive outcome (i.e. permanent housing placement).

HUD has recently published *System Performance Measures: An Introductory Guide,* which provides more information about performance measures.

These performance measures allow for cross- program comparisons to determine what programs achieve the best outcomes. For example, a transitional housing program could be compared to other transitional housing programs or to rapid re-housing programs to determine which program results in better outcomes for families experiencing homelessness. Furthermore, each of these measures is directly related to the goal of ending homelessness.

The steps for completing a performance and outcome analysis in your community are as follows:

- Set a few high priority community goals;
- Craft specific measurable outcomes to assess an individual program's contribution to those goals similar to the ones shown above;
- Ensure that the outcome measures account for the level of barriers faced by households to prevent incentives for screening people out of programs. This can be done by creating separate measures related to barrier levels or by embedding barrier levels in each measure (e.g. the percentage of program participants with high barriers to housing who are in permanent housing when they exit the program); and
- Create a process to regularly measure these outcomes through your HMIS (except for domestic violence providers who may use a different data system).

Assessing the Impact of Reallocation

One challenging aspect of reallocation is assessing its impact on overall community performance. How will redirecting resources from one type of program to another affect outcomes? The Performance Improvement Calculator (http://www.endhomelessness.org/library/entry/performance-improvement-calculator) is a tool that helps model changes made through reallocation. For example, it can help you assess the change in the number of households your homelessness assistance programs would house by reallocating from transitional housing to rapid re-housing.

Creating a spending plan

After a CoC has analyzed its populations, programs, and performance, the next step is to create a spending plan to map out a course for future funding decisions. A five year spending plan can help your community's providers, funders, and key stakeholders prepare for resource changes, such as funding reductions, reallocation opportunities, or new funding sources like the Affordable Care Act. A spending plan should be guided by the analysis described above and an overall vision for the community's homeless assistance efforts. For example, if the community's goal is to ensure that no person experiences homelessness for more than 30 days, the spending plan would likely involve reallocating from longer term shelter and transitional housing programs to shorter term shelter, rapid re-housing, and permanent supportive housing.

Strategies	Total	New Funding	Reallocated Funding	Reduced Funding	New Annual Spending
TOTAL	$2,645,000	$230,000	$0	-$10,000	$2,865,000
Temporary Housing					
Emergency Shelter *1	$320,000	$50,000	$0	-$10,000	$360,000
Motels or motel vouchers	$100,000	$50,000			$150,000
Overflow/Seasonal Shelter	$0				$0
Year-Round Shelter	$220,000			-$10,000	$210,000
Transitional Housing *2	$850,000	$0	-$100,000	$0	$750,000
Site-Based Programs	$150,000				$150,000
Scattered-site Transition in Place (TIP)	$0				$0
Scattered-Site (not TIP)	$700,000		-$100,000		$600,000
Permanent Housing					
Permanent Supportive Housing	$1,000,000				$1,000,000
Rapid Re-Housing	$100,000	$100,000	$100,000		$300,000
Homelessness Prevention	$0		$25,000		$25,000
Services					
Employment	$200,000				$200,000
Outreach	$75,000		-$25,000		$50,000
Child Care	$0	$50,000			$50,000
Health/Medical/Clinic	$0				$0
Substance Use Treatment/Services	$0				$0
Mental Health Treatment/Services	$0				$0
Oversight					
Data/HMIS	$50,000				$50,000
Coordinated Assessment	$0	$30,000			$30,000
Coordination/Planning	$50,000				$50,000
Other	$0				$0

A spending plan begins with an inventory of current programs and the amount of resources dedicated to each type of program. The chart on the right is an example of a spending plan for a fictional community. It shows how funding is currently distributed among homelessness interventions. It also shows the community's plans for utilizing new funding, how it plans to reallocate funding, and where it will lose funding.

A template and instructions for a spending plan, created by the National Alliance to End Homelessness, can be found here: http://www.endhomelessness.org/library/entry/the-continuum-of-care-spending-plan-template.

Discussing Next Steps

Once the CoC has engaged in strategic planning to determine what programs should be reallocated and to what extent, it is important that follow-up planning occurs with those programs being reduced or eliminated through reallocation. CoCs can refer programs being reduced or eliminated to the *Services in the CoC Program: Assessing Value and Finding Funding Alternatives* tool, which can be used to identify other funding sources for the supportive services that traditionally accompany HUD programs. This tool can also be found at http://usich.gov/usich_resources/coc-services.

SECTION 3: REALLOCATIONS AT THE PROJECT OR GRANTEE LEVEL

Once HUD has published its annual CoC Program Competition NOFA including what types of reallocations will be permitted in a given competition year, a CoC must determine whether they want to reallocate. For example, if the CoC's long term reallocation plan was that they need to create more permanent supportive housing for people experiencing chronic homelessness and this is one of the options in the NOFA, then the CoC should proceed with reallocating that year. The process of requesting a new reallocated project starts with the application, rating, and ranking process. It also involves deciding what to do with the project from which funds are being reallocated, particularly when that project offers site-based housing.

Preparing Project-Level Applications through Reallocations

All new reallocated projects are considered to be new projects by HUD. They can be for a brand new effort or an expansion of existing efforts. A new reallocated project may utilize the resources such as staff or buildings from a previous project. No matter the situation, a new project application is required to be submitted and ranked in *e-snaps.*

Completing a project-level application for any new reallocated project is not different from an application for any new project. Applicants must be eligible and project applications must meet the applicable NOFA's project quality standards and criteria for the particular project type (e.g. rapid re-housing or permanent supportive housing). Applicants must carefully review the NOFA to determine what types of new reallocated projects are allowed and what populations are eligible. Where an applicant is planning to change the program design of an existing project and keep some of the aspects the same, there are some key points that the applicant and CoC must be aware of. First, from HUD's perspective, it is still a new project and must meet all of the same criteria as any other new project application. If awarded, funds from the new reallocated project cannot pay to continue efforts under the old grant agreement and, in most cases, the participants in the existing project will not be eligible to be served under the new grant agreement. The applicant must also carefully consider what types of changes are needed to the existing program design in order to create a successful new reallocated project. This is particularly important for transitional housing projects that offer site-based or shared housing where participants currently do not have their own bedroom or where housing is not intended to be long-term or permanent. This type of housing, as is, may not be the most appropriate model of housing for permanent supportive housing, for example, and HUD will consider this when reviewing the project application. We discuss this further below.

It is also very important for recipients of projects that are being reallocated (who will also be the applicant for the new reallocated project) to understand that HUD will not consider the new reallocated project as a continuation of any effort. The new project will not be able to begin operating and incurring costs until after the grant agreement has been executed. It will not be made retroactive to the expiration of the former renewal project.

Continuing or Discontinuing Projects from which Funding has been Reallocated

When making decisions about which renewal projects to reallocate, the CoC and the recipient will need to determine if the existing project will cease operating altogether, whether some aspects of the existing renewal project will be able to continue under the new reallocated project (e.g., staffing), or if the project should remain the same but that the funding source will simply change.

CoCs can use the strategic assessment and planning process described in Section 2 to make these decisions. At a basic level, the decision on whether to discontinue this program or identify other sources of funding for the program should be based on the CoC's determination about whether that project or

program is contributing to its goal of ending homelessness. Specifically, the CoC can ask the question of whether the program is contributing significantly to reaching the highest need people experiencing homelessness, helping them to obtain and maintain permanent housing, and if the program is contributing to system performance measures. If the project is not directly or significantly contributing to this outcome, the CoC may consider discontinuing the project being reallocated altogether.

In some instances, a CoC may determine that certain aspects of an existing project may be able to continue under the new reallocated project, such as staffing or certain supportive services that are offered. In these cases, the CoC should work with the recipient of the renewal project and help them identify both a transition plan for current project participants and how the project will bridge the gap between when the renewal grant expires and when the new reallocated project will begin.

The CoC may also decide to reallocate funds from an existing renewal project if funds from another source have been identified to pay for those same activities. Part of the reallocation decision-making process should be considering all funding sources and determining if there are some costs and activities that could be paid outside of the CoC Program. There are many Federal, State, and local funding streams that can pay for housing and services for people experiencing homelessness. For supportive services costs in particular, CoCs are encouraged to utilize the USICH Services in the CoC Program: Assessing Value and Finding Funding Alternatives tool, which contains information on alternative Federal funding possibilities for supportive services costs currently paid for under the CoC Program.

Ranking and Reviewing Reallocated Projects

The CoC must review each project that is submitted for funding to ensure that it meets all NOFA requirements. It should make sure that the housing being offered will be appropriate, that the project applicant plans to serve all eligible households (and understand what those eligibility criteria will be) and that the budget does not contain any requests for ineligible costs. If a new reallocated project is not funded because the application did not meet HUD's requirements, the CoC will lose those funds, which are part of its Annual Renewal Demand, permanently.

Reallocating Site-Based Transitional Housing

Reallocating from Site-Based Transitional Housing to Permanent Supportive Housing

When the decision has been made to reallocate funds from an existing site-based project, the CoC must determine if the project ever received funds for new construction, acquisition, or rehabilitation. If the answer is yes, then there is likely a restrictive covenant in place that limits what can be done with that property for a specified period of time. Even where no HUD funds were used for capital costs, there may be State or local funds that were used for that purpose and as such there may be restrictions from the State or local government that limit how the property can be used. In some cases, the CoC or recipient may find an alternative use for the property that meets the requirements of the restrictive covenant and the renewable funds from that project are reallocated to a brand new effort. However, this is not always feasible and many CoCs find themselves trying to re-use these properties in a new reallocated project. Rapid re-housing funded under the CoC Program may only be tenant-based, so it would be problematic for a CoC to request a new reallocated project where it proposed to use site-based housing. The most common scenario is the conversion of a site-based transitional housing project to a site-based permanent supportive housing project.

There are a number of special issues and considerations that arise when attempting to use the existing site for the new reallocated project:

- Ensuring compliance with building covenants
  The CoC and recipients must ensure that they understand and are compliant with any and all applicable restrictive covenants. Recipients of CoC Program funds must honor these covenants when considering new uses for these buildings. CoCs and their grantees should work with their HUD Field Offices and State and local governments to determine how to honor their covenants while considering the most strategic use of their buildings. In most cases, the covenants will allow for a change in the program design, provided that the property will continue to be used for certain purposes. Under the CoC Program, recipients with a restrictive covenant in place may submit a request to HUD to convert a project for the direct benefit of very low-income people.

- Assessing the feasibility and suitability for permanent supportive housing conversion
  In some instances, a building used for site-based transitional housing may be suitable to be repurposed for a new permanent supportive housing project. The feasibility of converting a site-based transitional housing program into permanent supportive housing depends on the current configuration of the building and whether this configuration meets (or can meet, with rehabilitation) the needs of the population to be served. Buildings with apartment style housing where participants have their own units will be easier to convert than buildings with a dormitory style configuration which would require substantial reconstruction if the building is to be used in the new permanent supportive housing program. When considering the conversion of the property it is important to keep in mind that permanent supportive housing is fundamentally different from transitional housing in the fact that the housing is intended to function as a person's or household's home, either indefinitely or for a long period of time. Simply removing time limits does not change the nature of the housing being offered and it may not necessarily be appropriate under the permanent supportive housing component.

  Where buildings are already designed with self-contained apartments the recipient and CoC still need to consider certain factors to determine if it is suitable for permanent supportive housing. These factors include the overall physical integrity of the building, current zoning, whether the physical layout and design meet housing quality standards and zoning, the neighborhood and proximity to amenities, and common and office space. Considerations for the population should also be made. For instance, a permanent supportive housing project for single adults may not require significant outdoor space, however this would be desirable for a project for families with children.

  Where buildings are designed with a dormitory style configuration, repurposing to permanent supportive housing is more challenging and may require rehabilitation. In those instances, recipients of CoC Program funds should determine whether it is feasible to pursue this conversion through a reallocation, given the costs, timing, and logistics of the rehabilitation. Recipients should work closely with the CoC and the local HUD field office. They should also retain architects and local housing development experts to assess whether the building(s) can be repurposed to permanent supportive housing, and to determine whether doing so is financially and practically feasible.

- Assessing the suitability and feasibility of repurposing for other uses
  If the building has been determined unsuitable for repurposing to a new permanent supportive housing project, the next step is to determine if there is another use that is still consistent with the restrictive covenant and which would allow the renewable funds to be reallocated to a new project. For example, the building could be converted for use as an emergency shelter, drop-in center, or social enterprise, or as affordable/low-income housing, and more. These other uses should be consistent with the project needs outlined by the CoC's strategic plan. The CoC should consider all funding streams that would allow for this type of conversion to occur.

It is important to note that the recipient should not take any action without consulting and receiving approval from the local HUD field office.

- Relocating current residents
  Where it has been determined that a site-based transitional housing project is going to be converted through reallocation to a new permanent supportive housing project, it is important to come up with a transition plan for the current program participants. Although it may be possible for people currently in transitional housing to be eligible for permanent supportive housing if they entered that program from the streets, emergency shelter, or safe haven, they would not be eligible for permanent supportive housing dedicated to serve people experiencing chronic homelessness. Therefore, the conversion plan should include a strategy for ensuring that all current program participants are assisted to move into alternate permanent housing in the community during the transition process. Relocation of existing residents becomes even more challenging if the conversion requires a building rehabilitation, in which case the rehabilitation will need to be done in phases as residents move out. Some of the challenges can be mitigated by pursuing a 'phased reallocation' approach (see below).

- Financial management in conversions
  The timing of when the competition process starts and CoC Program grants are awarded can make program conversions challenging. This is not only relevant to site-based programs, but is a factor to consider in this type of reallocation. HUD treats the reallocation process as the termination of one grant and the beginning of a new grant. These grants may not end and start on the same timeframe, there may be a gap in funding as an old grant expires, and there may be several months before a new grant agreement is executed. HUD's acceleration of the CoC Program application and award process should minimize or, in many cases, eliminate this challenge; however, it is an important factor for providers to explore. Depending on the circumstances, HUD may allow for the recipient to extend its current grant agreement to help close the gap between the renewal funding expiring and the operating start date of the new project. A provider may also consider asking other funders in the community to cover potential gaps in funding. Many funders, including community foundations and local governments, may be willing and able to fund these one-time expenses. Recipients and CoCs should regularly engage with private funders within the community to explore new funding options during the conversion process to ensure that there will be enough resources during and after the conversion process.

- Staffing
  Converting from a transitional housing project to a permanent supportive housing project may involve a change in staffing. Again, this is not only relevant to site-based programs, but is a factor to consider in this type of reallocation. Depending on the staff ratios in the transitional housing program, more staff may need to be hired (and more staff positions funded). Effective permanent supportive housing programs serving people experiencing chronic homelessness typically have tenant to staff ratios of between 8:1 and 12:1. Staff typically is skilled in mental health services, substance abuse services, and health care services. It is not necessary for provider staff to have expertise in all these areas if they can partner with organizations such as community health centers to help meet the needs of program participants.

- Adopting a Housing First approach
  One of the most important changes when moving from transitional housing to permanent supportive housing is moving towards adopting a Housing First approach. While a Housing First approach is not required for operating permanent supportive housing under the CoC Program, it is considered by USICH and HUD to be a best practice. Recipients of CoC Program-funded permanent

supportive housing are strongly encouraged to employ a Housing First approach to the maximum extent possible. In the FY 2013-FY 2014 CoC Program Competition, HUD scored CoCs based on the degree to which permanent supportive housing recipients were using a Housing First approach and this will likely continue to be a priority for HUD. Recipients of transitional housing that is being reallocated to permanent supportive housing where they will be the applicant and where staffing will, at least to some extent, remain the same will need to provide training to staff on this approach to ensure that it is implemented correctly. For more information on the Housing First approach, see HUD's *Housing First in Permanent Supportive Housing* brief.

- Board and community support
  Another critical part of this process is communicating changes to members of the community and ensuring community support. In many communities transitional housing has become a staple, and not all community members or organizations will understand the reasons for the change. In some cases, the change may impact other organizations within the community which will not be taken lightly. This is often the most time consuming part of the process. CoCs and recipients should strive to be transparent through the process and use data and the findings of the CoCs strategic analysis to help those within the community that are resistant to understand why it is necessary.

- Phasing in reallocations
  One challenge associated with converting a building that is currently serving program participants is the timing gap between funding that happens as a result of reallocation. This can at least be partially mitigated by phasing in the reallocation. Phasing in reallocations involves reallocating a portion of a project to be converted over two or more CoC Program competitions. To do so, a grant recipient would pro rate its grant (corresponding to beds or units).

  For instance, a grant recipient may apply to reallocate funding for half of the beds of a site-based transitional housing project into permanent supportive housing in one annual competition, and the other half in the following year competition. In this situation, the grant recipient would then have two concurrent grants for the same building—one for the transitional housing project and one for the permanent supportive housing project. It would be necessary for the recipient to keep the grants separate because the funds for transitional housing cannot be used to provide permanent supportive housing and vice versa.

  As the reallocated portion of the grant winds down, the grant recipient would relocate transitional housing residents in the reallocated portion of the building before it receives a grant agreement for its permanent supportive housing project. Once it receives its grant agreement from HUD, it would then lease up people experiencing chronic homelessness into its permanent supportive housing beds under its new grant award. The grant recipient can then choose to reallocate the remaining grant and convert the remainder of the building in the next competition.

  It is important to note that phasing reallocations does not fully resolve the timing gap in funding between the old and new grants, but can help ensure that there is some continuity of funds in order to maintain building operations and to allow for a more reasonable timeframe for the relocation of current residents.

One-to-One Reallocations from a Site-Based Transitional Housing Program

Special considerations also arise when a CoC decides to pursue a one-to-one reallocation from a site-based transitional housing program (where the entire grant for a transitional housing program is proposed for discontinuation.) Many of these challenges are the same as with a conversion to

permanent supportive housing as described above. However, the decisions to be made focus on identifying alternative uses of the building.

- Identifying alternative uses for the building
  In these situations, site-based transitional housing can be assessed for feasibility to be converted to permanent supportive housing or other uses. If the building is assessed as suitable for permanent supportive housing, the CoC has the option of applying for an additional reallocation of funds to fund this permanent supportive housing project, secure non-CoC Program resources, or, if applicable in the competition, apply for funding through the CoC Program permanent supportive housing bonus.

  If the building is not suitable for repurposing to permanent supportive housing or if a site-based permanent supportive housing is not needed, the CoC should consider other uses of the building that are consistent with any covenants. These can include an emergency shelter, drop-in center, social enterprise, affordable/low-income housing, or others, as determined by the CoC's strategic plan. These other uses will likely require funding from sources other than the Continuum of Care Program. The CoC could also work with the grant recipient and HUD field office to explore other options like selling the building (if it is owned) or ending the lease. The same issues with tenant relocation and board and community support are applicable.

- Current program participants
  In general, the households currently served by a transitional housing program will not be eligible for rapid re-housing. The conversion plan should include a strategy for ensuring that all current program participants are assisted to move into permanent housing in the community during the transition process.

- Evaluating funding sources
  Even if a provider is reallocating their CoC funding from transitional housing to rapid re-housing, they may have other, non-CoC resources on which they rely. It is important to communicate with funders and explore new funding options during the conversion process to ensure that there will be enough resources during and after the conversion process.

- Board and community support
  Transitional housing providers are typically cherished by many members of their organizations and communities. Throughout the conversion process, the leaders of the provider organizations will have to explain the reasons for the conversion and how it will affect all parties. This is often the most time-consuming part of the conversion process.

- Converting Transition in Place Programs to Rapid Re-Housing
  One type of transitional housing program, typically referred to as "Transition in Place" operates very much like rapid re-housing. Transition in Place programs usually involve a provider identifying available apartments in the community, helping households move in (either through a sublease arrangement or with the lease directly in the household's name), providing a temporary subsidy and services for up to 24 months, and then allowing the household to remain in the unit permanently with the household holding the lease. Because these programs are very similar to rapid re-housing programs already, the conversion process is very straightforward.

SECTION 4: CASE STUDIES ON REALLOCATION

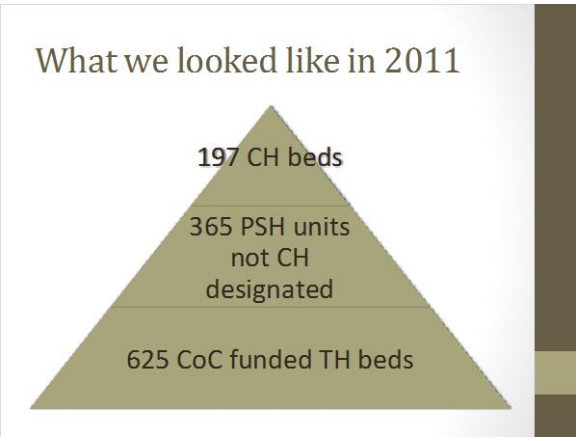
REALLOCATION IN MEMPHIS AND SHELBY COUNTY

In 2011, the City of Memphis and Shelby County Mayors announced the creation of a strategic plan formed out of analysis of local resources, best practice models, and research on effective interventions. The plan was put together with feedback and input from community stakeholders, review of *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, and came to be known as the Action Plan to End Homelessness. At the time, there were 1,187 beds in the CoC, 53 percent of which were transitional housing beds, and only 16.5 percent of which were permanent supportive housing for individuals or families experiencing chronic homelessness. There were 1,365 people served by CoC programs.

Strategic Approach

The Action Plan to End Homelessness contains 18 strategic elements, including the reprogramming of existing resources to reduce transitional housing by 50 percent and increase permanent supportive housing by 391 units and sustain a successful rapid re-housing demonstration funded with stimulus dollars. The plan also called for targeting permanent housing resources to the most vulnerable by using research-based, validated assessment tools to match people experiencing homelessness with the appropriate interventions.

The PIT count held in January of 2012 was considered the baseline count for the Action Plan and found 2,076 people experiencing homelessness, with 265 individuals experiencing chronic homelessness, and 326 people unsheltered.



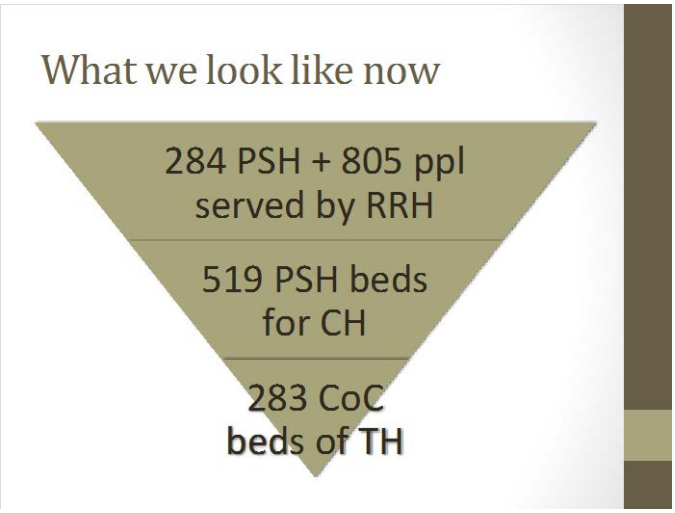
The Decision to Reallocate

In the summer of 2012, the Memphis and Shelby County Homeless Consortium (the local CoC) voted to implement the Action Plan's strategic targets by reallocating the lowest performing transitional housing programs serving individuals and families. One transitional housing program identified that it had performance and occupancy issues and chose to opt out of renewal. This left the Ranking and Review Committee to identify one program that had the lowest performance outcomes.

The approach to performance measurement included HEARTH Act driven measures and was adopted by the community around the same time. Agencies were provided a report card that showed the program's outcomes on each measure, a comparison to community averages, and a measurement of performance against established targets based on the top performance in each category. A site visit was used to verify that the information in the HMIS system matched the information in case files, to review financial management and any audit findings, and to discuss any programmatic or performance issues on a one-on-one basis with agency leadership.

In preparation for the 2013 Consolidated Application, the CoC convened regularly over a six month period to review and adjust the performance measures, refine the Ranking and Review process, and decide on how to address the 5 percent reduction called for by Congress. Ultimately, the CoC voted to place in Tier 2 the lowest performing program. The funding for another lower performing transitional

housing program was reduced. One program, after a roughly two-year process of analyzing its mission and housing programs with its Board of Directors, elected to withdraw its transitional housing program from the competition in hopes of expanding its rapid re-housing program funded with Emergency Shelter Grants (ESG) and private dollars. An open RFP process was held to allocate the funds made available through reallocation.



As a result of this two-year process of reallocation, transitional housing beds have decreased by 55 percent and permanent supportive housing beds targeted to the chronically homeless has increased by 322. The CoC's rapid re-housing program now has a renewable funding stream and has been enhanced with the introduction of SSVF, serving Veterans and their families. The CoC will now serve 1,891 people (an increase of 38.5 percent) with a more systematic, targeted approach to ending homelessness.

Results

The community has already seen the impact of these changes. Contrary to concerns that reducing transitional housing programs would result in an increase in homelessness, Memphis and Shelby County have seen the opposite occur. Homelessness in Memphis is down 19.3 percent in the two-year period. Chronic homelessness is down 44 percent and family homelessness is down by nearly 30 percent.

Reallocation is an effective tool to realign community resources to ensure funds are used to end homelessness, not just sustain programs. These are difficult decisions that require: 1) a strategic framework, developed with the input of local providers, 2) committed community leaders, including philanthropy and elected officials, and 3) annual refinement by and continuous communication among the CoC membership.

REALLOCATION IN MERCER COUNTY, NEW JERSEY

In 2008, Mercer Alliance to End Homelessness convened government partners in a year-long study process. This was accomplished by 1) analyzing research by Dennis Culhane on family shelter utilization, 2) researching best practices around rapid re-housing and 3) looking internally at HMIS data for emergency shelter and transitional housing projects. Finally, after participating in a 2009 HUD rapid re-housing demonstration project, Mercer County examined the three year data trend and identified a significant drop in the number of transitional housing units needed in the community. Comparative data between transitional housing and rapid re-housing showed that those in transitional housing with the highest utilization had the lowest need and did not exit to permanent housing. Moreover, the cost to the current system was more than $5 million annually.

Initial Reallocation from Transitional Housing to Rapid Re-Housing

In 2010, Mercer County made the decision to reallocate CoC Program funding away from transitional housing. A review of performance data showed that families were spending longer lengths of stay in transitional housing (387 days versus 54 days in rapid re-housing) and had lower rates of exiting to permanent housing compared to rapid re-housing. Mercer County spent a year building community consensus by reviewing, program by program, the needs of the population and the community. This reallocation planning coincided with the establishment of a Rapid Exit program for families experiencing homelessness using TANF dollars to fund rapid re-housing. These two planning processes worked in concert with one another to help redesign a system that would allow Mercer County to successfully reallocate funding for transitional housing with the least amount of disruption and to produce better outcomes. The 2012 CoC application process was used to reallocate funding from transitional housing. The CoC review team, comprised of the CoC lead agency, county administrators, a system monitor, and local project administrators looked at the proposed outcomes identified by the agencies in their application and each program's ability to meet HEARTH/HUD expectations. The team also reviewed both renewals and new projects using this criteria. This process allowed for reallocation from transitional housing to fund a rapid re-housing project with the reallocated funds.

Secondary Reallocations through Sequestration

In preparation for sequestration in the FY 2013 CoC program application, Mercer County recognized the need to make targeted, community focused decisions and build community consensus. The first step was to create a CoC Project Review and Ranking Policy which outlines the review and ranking process. Next, they created a new CoC Project Evaluation Tool to Evaluate Project Performance, Compliance and HMIS Data Quality. After reviewing the tool, further modifications were made to make it more comprehensive by adding in Fiscal Monitoring, CoC Priority Population and Project Capacity sections to the tool.

The CoC Review Committee convened a number of times to review the project information. An initial review indicated two underperforming projects: a permanent supportive housing project and a supportive services only program. The review team felt very strongly that both programs' resources should be reallocated to expand an existing higher performing permanent housing project and made that recommendation to the Executive Committee of the CoC. A team of experts was developed to work closely with both programs to prepare for the transition.

While the reallocation process can be overwhelming at times, with the right planning and tools, communities can successfully change homeless service systems to achieve an end to homelessness.

SYSTEM ANALYSIS FOR CREATING A MORE STRATEGIC HOMELESS RESPONSE SYSTEM IN PIERCE COUNTY, WASHINGTON

CSH created system analysis tools to provide communities with a lens on collective investments and performance to ensure accountability to HUD and other funders, show providers how their accomplishments contribute to system-wide outcomes, and inform continuous improvements. Thoughtful reallocations require both a system-level and project-level analysis to establish a more strategic system design.

One example of CSH's work in system analysis is with Pierce County, Washington. Pierce County has a substantial amount of transitional housing for families and wants to reduce its system-wide lengths of stay, access barriers, and program rules in order to move more families into independent housing faster. Pierce County is working with CSH to use the following system analysis tools to inform its reallocation strategy.

Investments Inventory
First and foremost, effective systems need to know how much they are spending to end homelessness. The Investments Inventory accounts for every public and private capital, operating, and service dollar on a per-project basis to establish system-wide totals and per-unit averages. Pierce County's Investments Inventory showed that the system has a substantial total investment in ending homelessness which, if used more strategically, could serve more families and possibly end family homelessness.

Project-level Analysis
Plans for system re-design should be rooted in a concrete understanding of the suitability of projects to convert. CSH scores each transitional housing project on six indicators of suitability to convert to shelter, higher-performing transitional housing, permanent supportive housing, rapid re-housing, or affordable housing that is prioritized for people who are experiencing homelessness. As a result of this analysis, Pierce County learned that many of its transitional housing projects are suitable to convert to rapid re-housing and that program rules need to be addressed in a new system design that will focus on independent housing.

System Map
The system map provides a visual depiction of the way people move through the homeless system. This is a powerful tool for visualizing who the system serves and its performance at a glance. Pierce County's system map provided the CoC with its first picture of the entire system's performance, which led to important questions that will inform future data entry efforts related to system design.

Projection Tool
A common and critical question asked by many CoCs when considering system redesign is how many units are needed of each intervention. CSH's Projection Tool determines the number of units, beds, or slots needed in each intervention to end homelessness based on the number of people who become homeless annually and the experiences of people who enter the system. Pierce County's projections showed that they have more transitional housing than they need and that significant increases in rapid re-housing with moderate increases in shelter and permanent supportive housing would move more people through the system faster.

Housing Market Analysis

Moving people through the homeless system faster and into independent housing will result in a greater demand for affordable and private-market rental units. The Housing Market Analysis evaluates housing stock, rents, and turnover rates in a community to allow CoCs to determine whether there is enough housing to support an increase in rapid re-housing. Pierce County's Housing Market Analysis found that families who were rapidly re-housed would only need two percent of the two-bedroom units and nine percent of the three-bedroom units that turnover annually in the county. The tool also offers a rent-burden calculator that shows rent burdens based upon income levels relative to average rent costs in the private market.

Conversion Technical Assistance

Many questions come up during a reallocation process. Technical Assistance can help both funders and providers to ensure that the CoC is moving in a direction supported by HUD and in a way that works for the local community. Pierce County is working closely with CSH to educate funders of homeless housing and services about the move toward a new system design and the need for reallocation. Conversion will also include trainings in best-practices for providers and funders who are shifting to new interventions.

SECTION 5: ADDITIONAL RESOURCES AND INFORMATION

- USICH's Blog on on HUD's FY 2014 Continuum of Care Program Competition

  USICH published a blog on the FY 2014 Continuum of Care Program Competition, which discusses HUD's policy priorities outlined in the combined FY 2013 – FY 2014 CoC Program Competition NOFA. These policy priorities focus on accelerating progress on the goals of *Opening Doors: the Federal Strategic Plan to Prevent and End Homelessness*.

  To access this resource, visit http://usich.gov/blog/building-systems-to-end-to-homelessness-huds-fy-2014-continuum-of-care-prog.

- USICH Webinar on HUD's FY2014 Continuum of Care Program Competition: Strategies for Continued Success

  This webinar provides an overview of the results of the FY 2013 competition, the unique aspects of the FY 2014 CoC Program funding competition, the permanent supportive housing bonus to serve people experiencing chronic homelessness, and tips for reallocations and prioritization.

  To access this resource, visit: http://usich.gov/media_center/videos_and_webinars/hud-fy2014-coc-program-competition-strategies-for-continued-success-1

- NOFA Analysis Part 1: Reallocation

  The National Alliance to End Homelessness published a series of blogs on the FY 2013 Continuum of Care Competition Notice of Funding Availability (NOFA). Part 1 focused specifically on reallocations through the CoC Competition.

  To access this resource, visit http://www.endhomelessness.org/blog/entry/nofa-analysis-part-1-reallocation#.VC1jLWddWE0.

- Community Performance Improvement: Using Reallocation Strategies to Meet System Needs

  Communities use performance standards and reallocation strategies to effectively change their homeless service systems. This HUD resource highlights communities that have implemented performance standards and reallocation strategies to ensure that they have the right components to effectively reduce homelessness.

  To access this resource, visit http://b.3cdn.net/naeh/e77d83a52b78179501_r3m6iy7zr.pdf

- Virginia Reallocation, Challenge Grants, and System Design Clinic Webinar

  This webinar, which was held for CoC leads in Virginia, discusses how to reallocate CoC funds, the CoC Challenge Grants, and the upcoming Homeless System Design Clinics. The webinar slides are available to view.

  To access this resource, visit http://www.endhomelessness.org/library/entry/virginia-reallocation-challenge-grants-and-system-design-clinic-webinar.

- Reallocation in Memphis: A Community's Survival Guide

This is a power point presentation prepared by Community Alliance for the Homeless, Inc. in Memphis, Tennessee, which provides tips and tools for the reallocation process.

To access this resource, visit http://b.3cdn.net/naeh/368458062743515776_6um62zh14.pdf.

- Office of Special Needs Assistance Programs' Presentation on Reallocating Projects

  The Community Planning and Development Office of Special Needs Assistance Programs at HUD did a presentation on reallocating projects, describing the reallocation process, how to decide what projects to reallocate, and more.

  To access this resource, visit http://b.3cdn.net/naeh/368458062743515776_6um62zh14.pdf.

- Using Reallocation to Support Strategies that Work

  This is a PowerPoint presentation prepared by The Homeless Planning Council of Delaware that describes their rationale for reallocating, when to do so, and tips for other communities.

  To access this resource, visit http://b.3cdn.net/naeh/e35fb913f8b8debb2e_adm6bkl49.pdf.

- Webinar: Reallocating Continuum of Care Resources

  On this webinar, the National Alliance to End Homelessness discussed how CoCs can reallocate resources, including how to review existing projects, identify gaps, and create new projects through reallocation. This webinar is for CoC lead agencies and those considering reallocation, and was originally held for CoCs in Virginia.

  To visit this resource, visit http://www.endhomelessness.org/library/entry/reallocating-continuum-of-care-resources.

- CSH's System Analysis Work

  For more information on CSH's System Analysis work, please contact consulting@csh.org.

National Alliance to End Homelessness

Center For Capacity Building
National Alliance To End Homelessness

One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families

INTRODUCTION

By centralizing intake and program admissions decisions, a coordinated entry process makes it more likely that families will be served by the right intervention more quickly. In a coordinated system, each system entry point ("front door") uses the same assessment tool and makes decisions on which programs families are referred to based on a comprehensive understanding of each program's specific requirements, target population, and available beds and services.

Uncoordinated intake systems cause problems for providers and consumers. Families with housing crises may end up going to multiple agencies that cannot serve them before they get to the one most appropriate for their needs. Each agency may have separate and duplicative intake forms or requirements, slowing down families' receipt of assistance, and each interaction with an agency opens up a need for data entry into a Homeless Management Information System (HMIS) or a similar system. Extra staff, time, and money are spent doing intake and assessment, taking time away from other, more housing-focused, tasks such as case management, housing location, and landlord negotiation. Research suggests that, in many systems, resources are being conferred on a small subset of families whose needs may primarily be economic, while those with more significant challenges (co-occurring disorders, complete lack of a social support system, etc.) are falling through the cracks.[1] Centralized intake makes it easier for communities to match families to the services they need, no matter how difficult their barriers are to address.

For these reasons and others, homeless assistance systems may wish to consider shifting toward a coordinated entry model. This paper will cover how communities can create a coordinated entry system with a focus on serving homeless families.

CHOOSING A MODEL

Different Types of Coordinated Entry

There are two general models for coordinated entry systems – centralized and decentralized. A geographically centralized front door has one distinct location where every family can go to access intake and assessment, while a decentralized coordinated entry system offers multiple sites for intake and assessment. A virtual or telephone-based centralized intake provides one number that consumers can call to access intake and get referrals. Additional

[1] Culhane, Dennis P. Stephen Metraux, Jung Min Park, Maryanne Schretzman, and Jesse Valente. "Testing a Typology of Family Homelessness Based on Patterns of Public Shelter Utilization in Four U.S. Jurisdictions: Implications for Policy and Program Planning" *Departmental Papers (SPP)* (2007).

differences between the models are discussed in the chart below. Regardless of the model, intake staff should be able to help consumers access prevention, diversion, and rapid re-housing resources; use an effective assessment tool; and provide information about local homeless assistance programs, housing resources, and community-based mainstream services. Intake centers and shelters should also be equipped with information about available affordable housing units, rental subsidies, and landlords willing to rent to consumers.

Centralized vs. Decentralized Coordinated Entry

	Physically/ Geographically Centralized	Centralized Telephone (i.e. "211")	Decentralized
Physical Requirements	A single location building, room, or space	Space for phones/hotline staff	Multiple coordinated locations throughout the community
Ideal Community	Physically small communities or communities with reliable public transit systems	Any; may be particularly useful in physically large or spread-out communities	Physically large or spread-out communities
Ideal Staffing	Workers who can handle intake and assessment (may or may not be case managers)	Workers who can handle intake and basic assessment	Workers who can handle intake and assessment (may or may not be case managers)
Ideal Services	Intake and assessment; connection to diversion, prevention, and rapid re-housing resources; referrals to other services; other services as decided by the community	Intake and assessment; referrals to other services; other services as decided by the community	Intake and assessment; connection to diversion, prevention, and rapid re-housing resources; referrals to other services; other services as decided by the community
Drawbacks	Center may not be equally accessible to everyone	Need for additional referrals/in-person help may slow down the process of getting services/housing	Less control over consistency of services and data management; potentially more costly (may require more staff, more space than physically centralized model)
Advantages	Fewer sites necessary; no time/training needed to work on coordinating multiple providers	Easier to handle a larger number of clients	More locations available to clients

Physically/Geographically Centralized Intake

Centralized intake offers those seeking services one location – physical or virtual – where they can enter the homeless system. For this reason, the physically centralized intake model is most appropriate for those areas that are small and/or have a reliable and comprehensive mass transit system. The advantages of this model are that the same staff person or people will deliver the assessment to every person requesting services, ensuring consistency in assessment administration and data collection. For centralized intake to work, providers must be confident that they will receive quality referrals as a result of the intake process. Transparency and collaboration go a long way toward creating this kind of trust.

Some communities may have separate intake centers for different populations (e.g., singles and families). This kind of set-up would still be an example of a centralized approach.

Centralized Model Example: Hennepin County, MN

In Hennepin County, Minnesota, all families must meet with a member of the Shelter Team at the Hennepin County Social Services building, the only entry point for families to the homeless assistance system, before they can access one of the County's two family shelters. Shelter workers use a triage tool with each family that captures information about where they last stayed, the benefits they currently receive, and their financial resources. Shelter Team members also begin assessing families on their employability and their eligibility for programs like Women, Infants, and Children (WIC), Temporary Assistance for Needy Families (TANF) cash assistance, Head Start, Legal Aid, etc. and ask families about other potential housing options outside of shelter. Shelter entry is viewed as a "last resort" option to be used when no other resources (like alternative housing or prevention) are available or appropriate. A Rapid Exit Coordinator (REC), who assesses each family for rapid re-housing eligibility, meets with the family within 72 hours of their entry into shelter. Shelter stays for a family can only be extended after this meeting if the REC determines there are no better housing options available for them at the time. Using this centralized intake strategy, Hennepin guarantees all families are assessed using the same tool and begins linking families to the appropriate services and a rapid re-housing plan immediately.

Centralized Telephone Example: Memphis/Shelby County, TN

Memphis and Shelby County, Tennessee put their Homelessness Prevention and Rapid Re-housing Program (HPRP) funds to good use by creating a telephone-based centralized intake for homeless families in October 2009. Several different agencies, including providers, share responsibility for staffing the 24-hour hotline, which received 18,000 calls in one year's time. Staffers were able to connect families to HPRP benefits as well as resources and programs like eviction prevention, rental assistance, food stamps, and cash assistance. Only 6 percent of the families requiring face-to-face assessments ended up going to a shelter or transitional housing. Memphis saw a 6 percent decrease in family homelessness and a 14 percent decrease in length of stay in emergency shelter and transitional housing between fiscal year (FY) 2009 and FY 2010.

Decentralized Intake

The decentralized intake model offers families multiple locations from which they can access services or shelter. The coordinated aspect of this model comes from the fact that each agency doing intake uses the same set of agreed-upon assessment and targeting tools; makes referrals using the same criteria; and has access to the same set of resources. Larger communities, or communities without a transit system to support everyone coming to one centralized location, may find the decentralized approach easier to implement. However, an increase in the number of organizations a community has participating in the system entry process may increase the likelihood of variation in terms of how assessments and referrals are handled. This particular issue may make the decentralized model less desirable for some communities than a centralized model that uses staff from only one organization.

Decentralized Model Example: Alameda County, CA

Consumers in Alameda County with a housing crisis go to one of eight Housing Resource Centers (HRC) in the region (six geographically spread-out centers and two population specific centers) to access intake. Consumers can also access the HRCs through a 211 line. At the HRCs, staff members conduct in-depth assessments of consumer needs. Using the information obtained from a common assessment, each household is given a score and referred to financial assistance and/or case management and provided with prevention, rapid re-housing, and/or housing location services, as well as any other resources they might need.

Despite the fact that HRCs are spread throughout the region, each Center remains coordinated with the others. All eight HRCs use the same assessment tool, data collection methods, and targeting strategy, and each is co-located with different services that homeless assistance users may need. Staff members at each Center include a mix of program assistants, case managers, housing specialists, Center coordinators, and finance personnel. Communication among staff at different HRCs happens at monthly in-person meetings and online. The data collected at each Housing Resource Center is used in an ongoing effort to improve targeting and service efforts over time.

Sample Program Structure

Though program set-ups can vary greatly, here are two examples taken from Alameda County of what the staffing of a coordinated entry intake center might look like:

Center Serving Approximately 400 Households per Year

- 1 full-time (FT) Program Compliance Manager
- 1 FT Intake Specialist
- 2 FT Case Managers

Center Serving Approximately 120 Households per Year

- 2 FT Case Managers
- 1 Housing Specialist
- .4 Clinical Supervisor
- .3 Supervision/Program Coordination

- .35 Intake and Data Entry Specialist
- .05 Housing Inspector (purchased hours of a city-employed housing inspector who inspects units for housing quality and the presence of lead)

ASSESSMENT AND TARGETING

A well-developed assessment tool helps communities determine the best program match for each homeless family coming to the front door. Assessments at the intake center do not need to delve into consumer's histories very deeply; they simply need to gather enough information to determine which intervention and program are the best fit. When developing an assessment form, communities should take cues from other communities' forms, examine required data elements from HMIS and funders' data collection requirements, and gather information on:

- Where the family slept last night;
- The family's reason for coming to the center;
- The last time/place the family was in permanent housing; and
- The family's income.

First Step: Assessment for Prevention/Diversion

Everyone coming in the door of an intake center should be assessed immediately to determine if they are eligible for prevention or diversion assistance. Prevention resources can help those families that are not yet homeless, while diversion resources can be used to assist those seeking shelter to find or maintain housing options outside of the traditional shelter system. Those families eligible for prevention and diversion may need access to financial assistance for rental and utility payments, rental arrears, etc. They may also need access to a case manager to help with conflict resolution or housing stabilization.

Referral to Shelter

Those families that do not qualify for prevention and diversion assistance may need to be referred to emergency shelter until they can be rapidly re-housed or enrolled in another more appropriate program. Shelters should:

- Work to minimize the amount of time families need to spend there by beginning the development of a permanent housing plan as soon as possible;
- Have services focused on providing permanent housing as quickly as possible; and
- Link families to community-based supports.

Shelter beds should be viewed as a resource to be used only when absolutely necessary.

Second Step: Assessment for Rapid Re-Housing Eligibility

Once in shelter, families should receive a comprehensive rapid re-housing assessment within the first week. This more comprehensive assessment or triage tool should be used to determine what barriers this particular household may have to entering and retaining permanent housing and how serious these barriers are.

Effective rapid re-housing requires case management and financial assistance, as well as housing search and location services. Though available units may at times seem scarce, oftentimes this problem can be overcome by good relationships with landlords, being flexible on lease terms, or offering landlords more money up front.

Third Step: Assessment and Referral to More Intensive Interventions

The small percentage of consumers unable to be served by prevention, diversion, or rapid re-housing programs will most likely need more intensive housing and service interventions, such as substance abuse treatment, transitional housing, or permanent supportive housing. Domestic violence survivors who are not eligible or appropriate for prevention and rapid re-housing services may also fall into this category, and might best be served by a referral to a domestic violence shelter. To find out more about serving domestic violence survivors who are eligible to be served with prevention and rapid re-housing services, please see the Alliance's paper on the topic: http://www.endhomelessness.org/content/article/detail/3822.

MAKING THE TRANSITION TO COORDINATED INTAKE

System Considerations

1. Preparing for coordinated entry provides an excellent opportunity for communities to assess what services they have available and what services are lacking. This "system mapping" is one way that communities can see who their stakeholders are, what services they provide, and how they fit into the larger system. If there are a number of providers that are all providing the same type of services to the same population (for example, five different families-only transitional housing providers), the community should evaluate what unique services each one can provide and what opportunities exist for collaboration and consolidation.

2. Effective coordinated entry requires that the staff performing intake and assessment functions have a thorough understanding of the services available in the community. Communities might consider having a database or some other information source that can be easily updated and contains provider names, locations, hours of operation, services provided, etc. Intake staff should circulate this list on a regular basis to the rest of the homeless assistance provider community to ensure all the information listed is accurate.

3. Getting providers to buy in to the idea of releasing control over the intake process may be difficult at first; however, it is necessary for a coordinated entry system to be successful. Communities wishing to adopt a coordinated approach should discuss the following benefits with providers:

- A more coordinated intake process will take the pressure off of their staff to assess eligibility, since everyone needing assistance will be assessed at the front door.
- Under a coordinated system, providers will know that the people coming to their programs are already eligible for their services.
- Developing a coordinated entry process is one of the many ways a community can incorporate the systems-focused approach encouraged by the HEARTH Act.

Though coordinated entry typically means that providers accept whoever is referred into their program, some communities may allow providers to refuse services to a small percentage of referred households. Dayton/Montgomery County, Ohio, for example allows providers to reject some referrals, but often requires a "case conference" at which the intake worker, program staff, and client all meet to discuss an alternative housing strategy for the consumer. Case conferencing allows providers to have some say in the admissions process, but also fosters a sense of system-wide accountability for meeting the needs of each homeless family.

4. Coordinated entry requires trained intake staff at a minimum. Communities may need to re-assign staff from other organizations to take on this duty or train and hire new staff to perform it.

Program Considerations

1. Programs should carefully assess how their own program resources can best be used to end homelessness. Information gained from HMIS data, staff observations, available funding streams, and a community-wide needs assessment of the need for and availability of interventions needed to serve families experiencing homelessness should inform these assessment efforts. Some programs may end up having to change their service strategies dramatically based on their findings.

2. Providers should prepare staff for changes to their intake process and eliminate "side doors," access points to services that exist outside of the centralized system. This means programs will have to learn to reject requests for admission for a client from individuals or organizations with which they may have a personal relationship, and refuse to accept new clients unless they have been referred from the intake center.

EVALUATION

To ensure that the coordinated entry system is meeting the needs of homeless families and allocating a community's resources properly, there must be an on-going evaluation of how efficiently the homeless assistance system is functioning. This will involve taking a close look at changes in HEARTH Act outcomes and the paths consumers are taking through the

system to reach permanent housing. It will also involve adjusting the system, if necessary, to improve performance.

Evaluation of a coordinated intake system can be accomplished in several ways. Recently housed consumers can be given brief questionnaires to gather information about their experience with the system. Responses should be analyzed based on when the consumer first made contact with the homeless assistance system and when they were placed into permanent housing. Communities will want to see if, since the implementation of a coordinated entry model, the time from system entry to permanent housing has gotten shorter and involved fewer interactions with different agencies. These surveys can also ask consumers how they accessed services; if they did not access them through the intake center, the community will know that some side doors in the community still exist.

While coordinated intake is certainly not only the factor that influences outcomes on these measures, systems will still want to check in for the following trends in HEARTH outcomes after the coordinated entry system has been a place for a set period of time:

- Length of stay, particularly in shelter: If consumers are referred to the right interventions, and those interventions have the necessary capacity, fewer families should be staying in shelter waiting to move elsewhere. Also, if families are referred to the right place right away, over time, they will likely be spending less time jumping from program to program looking for help, which would reduce their overall length of stay in homelessness.
- New entries into homelessness: If everyone seeking assistance is coming through the front door to receive it and the front door has prevention and diversion resources available, more people should be able to access these resources and avoid entering a program unnecessarily.
- Repeat episodes of homelessness: If families are sent to the intervention that is the best fit the first time, they should have a better chance at remaining stably housed.

As part of the evaluation process, communities should establish a feedback loop that involves using the information gained from these assessments to make any necessary adjustments to the system. For example, if families are being referred to the right program, but that program cannot serve them due to capacity issues while other program types have an increasing number of empty beds, it may be time to make system-wide shifts in the types of programs and services offered. Communities with a coordinated entry system tracking tall their data have a centralized source of information on who is entering their system, who is on a wait list, what their needs are, and how those needs match with what's currently available. Disseminating this information to everyone in the service provider community will create an opportunity to improve the system as a whole. Tools to help communities conduct these evaluations will be available on the Alliance website soon.

CONCLUSION

Coordinated entry offers a more organized, efficient approach to providing homeless families with services and housing by creating quicker linkages to programs and matching

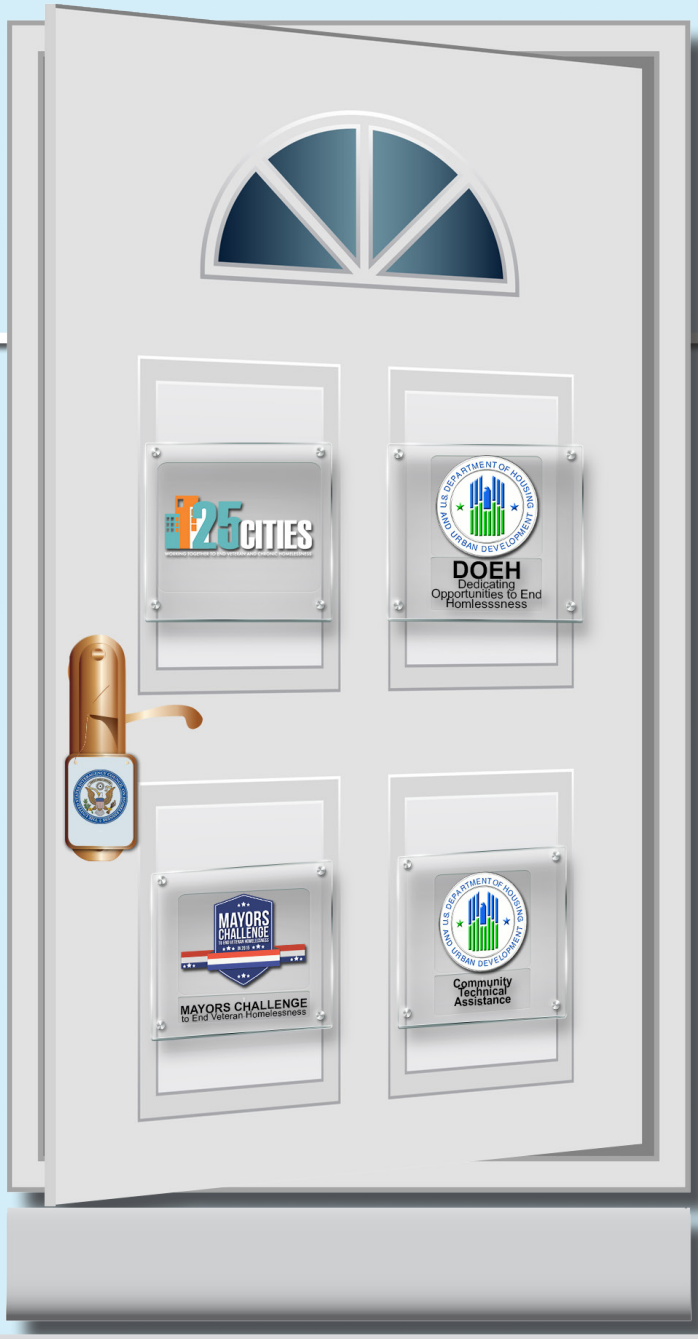
families' needs to providers' strengths. When implemented effectively, it simplifies the roles of providers, shortens the path back to permanent housing for homeless families, and fosters a sense of system-wide responsibility to place every homeless family, regardless of the complexity of their problems, into permanent housing as quickly as possible.

Complementary Federal Strategies for Ending Homelessness in Our Communities

Since 2010, the Federal member agencies of the United States Interagency Council on Homelessness have collaborated with local communities on multiple fronts, with an overarching focus on supporting communities' capacity to achieve the goals of ***Opening Doors: Federal Strategic Plan to Prevent and End Homelessness***. Those four bold, audacious goals call for all of us to work together to:

- End Veteran homelessness by 2015
- End chronic homelessness by 2016
- End family and youth homelessness by 2020
- Set a path to end all types of homelessness

Some of the most recent and significant of these Federal–community collaborations include the 25 Cities Effort, the Mayors Challenge to End Veteran Homelessness, the Dedicating Opportunities to End Homelessness initiative, and HUD-Funded Technical Assistance. This document serves as a guide on how these initiatives work individually and how they can help communities achieve the goals of *Opening Doors.*



The **25 Cities** Effort is a key Federal strategy through which 25 communities are receiving technical assistance and are mobilizing local planning efforts and partnerships to create effective systems for aligning housing and services interventions through coordinated systems to end homelessness.

Led by VA, in partnership with HUD and USICH, the aim of this effort is to assist 25 communities in accelerating and aligning their existing efforts toward the creation of coordinated assessment and entry systems, laying the foundation for ending all homelessness in these communities. If the community is already developing a coordinated system that also targets specific populations experiencing homelessness – e.g., families with children, single adults, and/or youth – this initiative works to enhance that system to address the housing needs of all populations.

With support from technical assistance providers, leaders and teams from each community optimize access to existing housing opportunities, in turn accelerating the number of permanent housing placements each month for Veterans experiencing homelessness and individuals experiencing chronic homelessness. This supports community teams in setting aggressive 100-day "Rapid Results" goals – and in using these goals to stimulate innovation and increase collaboration.

Visit **www.25cities.com** for more information and a list of participating communities.

The **Mayors Challenge to End Veteran Homelessness** serves as a catalyst for expanding the political will necessary to end homelessness in our communities. On June 4, 2014, as part of the Joining Forces initiative, First Lady Michelle Obama announced the commitment of a growing coalition of mayors, governors, and county officials who have signed on to the challenge and called on additional mayors and local leaders to commit to ending Veteran homelessness in their communities by the end of 2015. Through the Mayors Challenge, mayors and other state and local leaders across the country will marshal Federal, local, and nonprofit resources to end Veteran homelessness in their communities. To aid the mayors in pursuit of the goal of ending homelessness among Veterans, the Federal government has provided resources and enforced programs to strengthen our country's homeless assistance programs. Currently, more than 250 Mayors and jurisdictional leaders have signed on and more are signing on every day.

For more information about how your community can join, visit **http://bit.ly/mayorschallenge**.

In 10 communities, the **HUD Dedicating Opportunities to End Homelessness** (DOEH) initiative complements these other strategies by seeking to identify affordable housing resources that can be engaged in local efforts to end homelessness, expanding the supply of housing needed to achieve local goals. Led by HUD, in close partnership with USICH, the DOEH initiative is at work in Atlanta, Chicago, Fresno County, Los Angeles County, Houston, New Orleans, Philadelphia, Phoenix/Maricopa County, Seattle, and Tampa, helping to leverage mainstream HUD-funded housing resources, including public housing, Section 8/Housing Choice Vouchers, and Multifamily housing units, to achieve their goals of ending homelessness. Through DOEH, Federal partners, housing providers, and community stakeholders have created and implemented community-driven plans to leverage these identified resources, drawing upon local data and supporting existing local initiatives and plans.

HUD-Funded Technical Assistance (TA) can help provide the detailed, expert guidance and advice necessary to implement local plans efficiently and successfully. This TA is provided to Continuums of Care (CoC) and is focused on improving local capacity to address homelessness in communities to move the needle on homelessness nationally. The TA seeks to prepare communities for the changes required under the HEARTH Act and to align practices and policies with *Opening Doors*. The TA has especially focused on CoC governance and structure, annual outcome or performance evaluation, centralized or coordinated intake/assessment, systems analysis, and the Homeless Management Information System (HMIS). The TA is tailored to each community, allowing each CoC to focus on the most relevant objectives and activities. It is delivered using varying timelines and methods and uses a range of materials, including expert consultation, community planning tools, and topic-specific resources.

To learn more about how these initiatives are working together in your community, please contact the appropriate USICH National Initiatives Team Member.

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ASSISTANT SECRETARY FOR HOUSING-
FEDERAL HOUSING COMMISSIONER

Special Attention of:

Multifamily Hub Directors
Multifamily Program Center Directors
Rural Housing Services (RHS) Directors
Supervisory Housing Project Managers
Housing Project Managers
Contract Administrators
Multifamily Owners and Management Agents

NOTICE: H 2013-21

Issued: July 25, 2013

Expires: This notice remains in effect until amended, revoked, or superseded.

Subject: Implementation and approval of owner-adopted admissions preferences for individuals or families experiencing homelessness

I. Purpose: This Notice provides guidance to HUD field offices, contract administrators, and property owners on the circumstances under which owners of assisted properties may adopt admissions preferences. This notice clarifies 24 CFR §5.655(c)(1) - (c)(5) to allow for owners to adopt, with HUD approval, admissions preferences not specified there, in particular, preferences to house homeless families.

II. Background: The Office of Multifamily Housing Programs (Multifamily Housing) had strictly interpreted 24 CFR §5.655(c)(1) - (c)(5) *Section 8 project-based assistance programs: Owner preferences in selection for a project or unit*, to mean that owners were limited in adopting preferences in the selection of residents to those preferences specifically cited in the regulation. That interpretation did not allow for an owner to adopt a preference for homeless families, as owners could not adopt preferences outside of 5.655(c)(1) – (c)(5). However, in consultation with the Office of General Counsel, Multifamily Housing has revisited this issue and has broadened its interpretation to allow that silence within the provision does not preclude owners from adopting preferences outside of those cited.

III. Applicability: All Multifamily rental assistance programs.

IV. Definition of Homeless: The Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (HEARTH Act) revised the definition of homeless for HUD's

homeless assistance programs, and on December 5, 2011, HUD published its final rule implementing this definition. HUD will use this definition to track the number of homeless persons served in its programs starting in September 2013, after changes to the HUD form 50059 have been completed.

The definition of homeless under the HEARTH Act, however, does not prohibit an owner from establishing an alternative definition of homeless for the purpose of a waiting list preference based on local need. Owners may elect to adopt a more narrow definition specific to the homeless needs in their community or a broader version that would serve more of the population. Because of the specificity of this definition, owners must go to the HUD field office for approval. Owners are reminded that any preference must comply with civil rights requirements.

V. **Implementing a Homeless Preference:** Multifamily Housing owners can significantly increase program access for individuals and families experiencing homelessness by establishing an owner-adopted preference in admissions policies. Owners must consider the following when adopting an admissions preference.

a. **Eligibility and Requirements.** Preferences affect only the order in which applicants are selected from the waiting list. They do not make anyone eligible who was not otherwise eligible, and they do not change an owner's right to adopt and enforce tenant screening criteria. In addition, owners must inform all applicants about available preferences and give all applicants an opportunity to show that they qualify for available preferences including all applicants currently on a waiting list.

b. **Tenant Selection Plan and Affirmative Fair Housing Marketing Plan.** All owner adopted preferences must be included in the Tenant Selection Plan (TSP) and, if required, the Affirmative Fair Housing Marketing Plan for the associated property including any referral policy in the preference, if applicable. In addition, for preferences other than those specifically cited at 24 CFR §5.655(c), owner-adopted preferences must be approved by the local HUD office to confirm conformance with applicable regulatory and statutory requirements. Owners may remove their owner-adopted preference at any time without HUD approval. Any changes in preferences, however, must be updated in the owner's TSP.

c. **Using a Homelessness Definition.** Owners may create a preference for homeless families using the HUD definition of homelessness or a definition that better suits the property in question. The definition cannot exclude any protected classes, e.g., the definition cannot exclude families with children.

d. **Limiting preferences to people referred by a partnering organization.** Owners may create a preference or limited preference specifically for individuals or families who are referred by a partnering homeless service organization or consortium of organizations (for example, an organization that refers people

transitioning out of a shelter or temporary housing program). When partnering with a referring agency, an owner may elect to place the preference on the entire property or accept a referral for a defined percentage of units. No units may be set-aside or held off-line, but owners can fill vacancies by alternating selections from the existing project waiting lists with referrals from their partnering organization of eligible applicants who meet the preference criteria. For instance, in filling the next four vacancies, an owner may select three applicants for occupancy from the property waiting list followed by one applicant referred by the partnering organization. To allow for maximum flexibility, HUD is not prescribing the ratio of admissions. **Note:** Although a partnering organization may refer applicants, owners must screen those applicants in the required manner as they would for any other applicants on the waiting list. In addition, the source of referrals cannot be limited to an agency, organization, or consortia that exclusively provide services restricted to people with specific disabilities or diagnoses. Referrals also cannot be limited to an agency, organization, or consortia that deny services to members of any Federally protected class under fair housing laws, *i.e.*, race, color, religion, national origin, sex, disability, or familial status.

e. **Use of Alternating Selection.** Even if not partnering with a referral agency, owners may fill vacancies in the property by alternating their selections of non-homeless applicants on the waiting list with applicants who meet the criteria for the preference. This method of selection of residents must be clearly defined in the Tenant Selection Plan.

f. **Identifying preference-qualified applicants currently on the project's waiting list.** When adopting a new preference, owners must notify all applicants on the current waiting list to determine if any are eligible under the preference (24 CFR §5.655(c)). The owner must specify on any public notice of a waiting list opening that current waiting list applicants may qualify for the preference. The notice must also include any other information new applicants and current applicants on the waiting list will need to know about how to successfully apply and establish their preference status, including any partnering agencies with whom the owner may be working to receive referrals or determine preference eligibility.

g. **Verifying preference eligibility.** If an owner adopts a preference or limited preference for individuals or families experiencing homelessness, the owner may require the individual or family to provide documentation to prove that they qualify for the preference, or may rely on a partnering homeless service organization to verify that the individual or family qualifies for the preference. When an owner establishes a partnership for referrals from a homeless service organization, he/she may allow the partnering organization to verify the individual's or family's preference qualification before the individual or family is referred to the owner.

h. **Property Designations**. If the owner has a property designation of elderly or disabled on all or some of HUD assisted units, this designation remains in effect despite the adoption of the new preference. For example, if the property is 100 percent elderly, then the homeless preference would not supersede this designation. Any qualified applicants benefiting from the homeless preference would need to meet both criteria, i.e. homeless and elderly. If the property has 10 units properly designated for individuals with disabilities, then an owner could not fill any of the 10 units with persons who met the criteria for the homeless preference unless they also met the eligibility requirements of the units.

i. **Ensuring Fair Housing compliance.** When adopting a preference or limited preference for people experiencing homelessness, an owner must ensure that the preference would not have the purpose or effect of excluding other eligible families from the program on the basis of race, color, national origin, religion, sex, disability, or familial status, or would create or perpetuate segregation. An owner must comply with all fair housing and civil rights law in the adoption of a homeless preference and the opening of the waiting list to homeless families that qualify for the preference. For example, an owner adopting a homeless preference cannot deny access to families with children. The owner must also ensure that programs or activities are administered in the most integrated setting appropriate to the needs of qualified individuals with disabilities. The owner should analyze demographic data of the waiting list population and of the population in the community and compare this to the demographic characteristics of those who would qualify for the preference to ensure that the preference does not create a disparate impact on a particular protected class from accessing the program. In addition, the owner must fully document his/her marketing practices in the Affirmative Fair Housing Marketing Plan if the owner chooses to market the preference. This HUD-approved plan can include referrals from shelters and other organizations that serve the homeless, but should be designed specifically for the community in which the property is located.

For more guidance on the Affirmative Fair Housing Marketing Plan, please reference the HUD Handbook 4350.3 REV-1, Chapter 4.

VI. **Submission and Approval of Preference Requests:** Owners must receive HUD approval in order to adopt an admissions preference not specified under 24 CFR §5.655(c)(1) - (c)(5). Owners must submit a written request to their local HUD Field Office specifying the type of preference with a full description of the preference and how it will be implemented. Criteria set forth in this Notice including a description of the notification process for those on the waiting list, tenant selection process and any changes to the AFHMP must also be included. HUD will approve an owner-adopted preference if it does not result in discrimination, violate civil rights or equal opportunity requirements, or conflict with statutory, regulatory, or program requirements. Subsequent occupancy reviews will ensure that the property has updated its Tenant Selection Plan and, if required, the Affirmative Fair Housing Marketing

Plan. Please see Chapter 4 of HUD Handbook 4350.3 for more details about the submission and approval of preference requests.

VII. **<u>Admissions Policies Regarding Criminal Activity and Substance Use/Abuse:</u>** Under federal laws and HUD regulations, there are certain policies for admission to a housing program which are mandatory for all Multifamily property owners, and others which the owners have authority/discretion to adopt, but are not required.

Owners must establish standards that prohibit admission of:

1. Any household containing a member(s) who was evicted in the last three years from federally assisted housing for drug-related criminal activity. The owner may, but is not required to, consider two exceptions to this provision:
    a. The evicted household member has successfully completed an approved, supervised drug rehabilitation program; or
    b. The circumstances leading to the eviction no longer exist (e.g., the household member no longer resides with the applicant household)

2. A household in which any member is currently engaged in illegal use of drugs or for which the owner has reasonable cause to believe that a member's illegal use or pattern of illegal use of a drug may interfere with the health, safety, and right to peaceful enjoyment of the property by other residents;

3. Any household member who is subject to a state sex offender lifetime registration requirement; and

4. Any household member if there is reasonable cause to believe that member's behavior from abuse or pattern of abuse of alcohol may interfere with the health, safety, and rights to peaceful enjoyment by other residents. The screening standards must be based on behavior, not the condition of alcoholism or alcohol abuse.

Owners may also establish additional screening criteria, as outlined in HUD Handbook 4350.3. However, owners should bear in mind the length of their waiting lists and the cost to applicants for screening when considering additional criteria. In addition, some of these criteria can be a barrier for vulnerable populations, including people who are homeless, to accessing the programs. For example, an owner may have strict policies related to criminal backgrounds, and previous rental housing history which can have the effect of screening out the most vulnerable people experiencing homelessness who are more likely to have past convictions, past evictions, or previous debts, due to a variety of reasons, including mental illness and substance use disorders.

An owner wishing to serve more people experiencing homelessness should consider reviewing his/her discretionary admission policies to determine if any changes can be made to remove barriers. It is important to note that all discretionary admission (and program termination) policies must be applied to all applicants uniformly. In other words, an owner cannot have a certain set of admission/termination policies that apply specifically to a certain

population, such as the homeless population, which are different from the admission/termination policies for all other applicants.

VIII. Consideration of Circumstances Regarding Admissions and Terminations/Evictions: An owner cannot establish separate admissions/termination policies for a certain population, such as the homeless population, which are different from the admissions/termination policies than for all other applicants.

In the event of receipt of unfavorable information about an applicant, consideration may be given to the time, nature, and extent of the applicant's conduct (including the seriousness of the offense). Consideration may also be given to factors which might indicate a reasonable probability of favorable future conduct, including: evidence of rehabilitation, and applicant's willingness to participate in social services.

IX. Service Provider as a Resource in Continued Occupancy: Service providers are important resources in ensuring that persons and families experiencing homelessness admitted to the property (and those in the property but at risk of homelessness) are provided the services necessary to remain stably housed and compliant with program requirements.

HUD field offices, contract administrators, and owners should establish working relationships or consider service agreements with the service providers to ensure that all parties stay committed to the family through their participation in the program.

X. Information Contact: Inquiries about this Notice should be directed to Yvette Viviani at Yvette.M.Viviani@hud.gov or Jonathan Kinsey at David.J.Kinsey@hud.gov.

Carol J. Galante
Assistant Secretary for Housing -
Federal Housing Commissioner

Information Collection

The information collection requirements contained in this document have been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520) and assigned OMB control number 2502-0204. In accordance with the Paperwork Reduction Act, HUD may not conduct or sponsor, and a person is not required to respond to a collection of information unless the collection displays a currently valid OMB control number.

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

Special Attention:

Public Housing Agencies administering the Housing Choice Voucher and/or Public Housing Programs; Public Housing Field Office Directors

NOTICE PIH 2013-15 (HA)

Issued: June 10, 2013

Expires: Effective until amended superseded, or rescinded

Cross References:
PIH Notice 2012-34 (HA)

Subject: Guidance on housing individuals and families experiencing homelessness through the Public Housing and Housing Choice Voucher programs[1]

1. **Applicability:** This Notice applies to public housing agencies (PHAs) that administer the Public Housing and/or Housing Choice Voucher (HCV) programs.

2. **Purpose:** The purpose of this Notice is to provide strategies that PHAs can pursue to expand housing opportunities for individuals and families experiencing homelessness through the Public Housing and HCV programs. This Notice clarifies the definition of homelessness for the purpose of IMS/PIC reporting, and provides guidance on HUD policies and program regulations related to the following topics: waiting list management and preferences; admissions policies regarding criminal activity, substance use/abuse, and rental history; program termination and eviction policies; and project-basing vouchers for Permanent Supportive Housing (PSH).

3. **Background:** On June 22, 2010, the United States Interagency Council on Homelessness (USICH) presented the nation's first comprehensive strategy to prevent and end homelessness titled, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* (Opening Doors), to the Office of the President and Congress. Opening Doors is focused on four key goals:
    a. Finish the job of ending chronic homelessness by 2015;
    b. Prevent and end homelessness among Veterans by 2015;
    c. Prevent and end homelessness for families, youth, and children by 2020; and
    d. Set a path to ending all types of homelessness.

[1] Throughout this Notice, when referring to people experiencing homelessness, the term 'individuals and families' is used to indicate both individual persons who are experiencing homelessness, as well as homeless families, which may include children. When referring to HCV or Public Housing applicants or participants, the following terms are used intentionally based on their definition and the relevant statute, regulation or rule being referenced: 1. Family – A person or group of persons with or without children approved by a PHA to reside in a unit with assistance under the HCV or Public Housing program. The number of family members is used to calculate subsidies and payments. 2. Household – includes everyone who lives in the unit, including foster children/adults and live-in aides. Household members are used to determine unit size.

The Office of Public and Indian Housing (PIH) is committed to working with our PHA partners to expand opportunities for individuals and families to access quality affordable rental homes, thereby achieving HUD's goal of utilizing housing as a platform for improving quality of life. PIH, in cooperation with the Office of Community Planning and Development (CPD) and USICH hosted two national convenings of PHAs and Continuums of Care (CoCs) titled, *Opening Doors: Expanding PHA Opportunities to House People Experiencing Homelessness*, one in Los Angeles on February 8, 2012, and the other in Washington, DC on May 24, 2012. These convenings allowed participants to: share best practices; identify barriers that PHAs encounter in meeting the needs of this population; and allow PHAs and Continuums of Care to provide feedback and ask questions of HUD.

This Notice builds on the lessons learned from the two convenings and seeks to provide guidance on issues related to serving individuals and families experiencing homelessness.

4. **Reporting Homelessness in IMS/PIC:** The HUD Form 50058 module in the IMS/PIC data system allows HUD to obtain information about participants in the Public Housing and HCV programs, including the homeless status of persons entering the program. The accuracy and reliability of this information is critical to tracking the collective progress in ending homelessness.

   Based on a review of PIC reporting on 4C (homeless at admission), many PHAs are not reporting in this field accurately, or are reporting "no" for all applicants, whether homeless or not. For all new admissions, PHAs **must** determine whether an individual or family was homeless at admissions. This information **must** be reported at question 4C on HUD Form 50058. PHAs may need to verify that their IMS/PIC software is compliant with this reporting requirement. The following section provides guidance on how to determine whether an applicant is homeless at the time of admission, including questions that a PHA may ask an applicant in order to determine their homelessness status. For additional information on the Form 50058, please see the Form HUD 50058 Instruction Booklet at http://portal.hud.gov/hudportal/documents/huddoc?id=50058i.pdf

5. **Definition of Homeless for the Purpose of Completing Question 4C on Form 50058:** The definition of a homeless family currently provided in the Appendix of the Form HUD 50058 Instruction Booklet reflects the original McKinney-Vento Homeless Assistance Act definition. The Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (HEARTH Act) revised the definition of homeless for HUD's homeless assistance programs, and on December 5, 2011, HUD published its final rule implementing this definition. This rule applies specifically to the Emergency Solutions Grants program, the Shelter Plus Care program, the Supportive Housing program and was incorporated into the Continuum of Care (CoC) Program interim rule, which HUD published on July 31, 2012; however, PIH is adopting only a portion of this new definition to apply to question 4C of the Form 50058 as well. While the HUD regulations maintain four categories for defining people who are homeless, the PIH definition for IMS-PIC reporting (Form 50058) is narrowed to the following two categories:

   Category 1: An individual or family who ***lacks a fixed, regular, and adequate nighttime residence***, meaning:

   a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; ***or***

b. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low- income individuals); ***or***
c. An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

Category 4: Any individual or family who:

i. Is ***fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking***, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; ***and***
ii. Has no other residence; ***and***
iii. Lacks the resources or support networks, e.g., family, friends, and faith- based or other social networks, to obtain other permanent housing

This definition shall be effective as of this Notice, and the Form HUD 50058 Instruction Booklet will be updated accordingly. **Note:** A PHA is permitted to adopt an alternative or narrower definition of homeless for the purpose of a waiting list preference based on local need. PHA's that do this, however, will still be required to use the definition cited above for purposes of reporting homeless of new admissions on the Form HUD 50058.

In order for PHAs to accurately report a new admission's homelessness status on line 4c of the Form HUD 50058, the PHA may find the following list of questions helpful in determining the appropriate response. If the answer to any of the following questions is yes, the PHA would mark "Y" for yes in field 4C of the Form HUD 50058 (homeless at admission).

1. Are you currently living in a car, on the street, or another place not meant for human habitation?
2. Are you currently living in a an emergency shelter, transitional housing, Safe Haven[2], or a hotel/motel paid for by a charitable organization or by federal, state or local government programs for low-income individuals?
3. Are you exiting an institution, including a hospital, substance abuse or mental health treatment facility, or jail/prison, where you stayed for 90 days or less?If so, were you living in an emergency shelter or place not meant for human habitation immediately before entering that institution?
4. Are you fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life threatening conditions for you or a family member, including a child, that has either taken place within your family's primary nighttime residence or has made the you afraid to return to your primary nighttime residence? If yes, do you currently have nowhere else to live and also lack the resources or support networks,

[2] A Safe Haven is a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who are on the street and have been unable or unwilling to participate in housing or supportive services

including family, friends, faith-based, or other social networks, to obtain other permanent housing?

Example 1: A family that was evicted from the home they owned because they were no longer able to make the mortgage payments and is living in their car **would** qualify as homeless.

Example 2: An individual that had previously lived in an emergency shelter and was admitted to the hospital for a 5-day stay **would** qualify as homeless.

Example 3: An individual being released from prison after a 3-year incarceration **would not** qualify as homeless based on the length of incarceration.

HUD does **not** require PHAs to collect documentation or third-party verification of any kind in order to verify an applicant's homelessness status for purposes of reporting in 4C of the 50058. Verbal self-verification by the applicant that any of the above criteria are true is sufficient. However, in order to verify homelessness status for a preference, PHAs must follow the verification requirements they establish in their written policies.

6. **Waiting List Management:** PHAs' waiting lists can be a barrier to individuals and families experiencing homelessness having access to the Public Housing and HCV programs. When waiting lists are long, an individual or family who lacks stable housing and reliable contact information may not be able to be reached when they come to the top of the waiting list or when waiting lists are purged, especially if it has been months or years after the application was submitted. Also, when PHAs reopen waiting lists for short periods of time, people experiencing homelessness can be left out of the application process due to a lack of information about the opportunity to apply.

   PHAs can take a variety of actions to allow homeless populations better access to their programs, including establishing a strong outreach strategy through service providers, strengthening their process for contacting applicants on their waiting list (e.g., contacting applicants via email or phone), establishing flexible intake and briefing schedules (e.g., provide a window of time for appointments), and establishing nondiscriminatory preferences in their admissions policies for persons experiencing homelessness, or a subset of such persons (e.g., chronically homeless, homeless veterans, homeless identified as most vulnerable through community-based assessment strategies, etc.). All actions taken must be in compliance with all applicable fair housing and civil rights laws. See 24 CFR 5.105(a).

7. **Homeless Admissions Preference:** A PHA's greatest tool for increasing program access for individuals and families experiencing homelessness is establishing a preference in their admissions policies. This section describes the criteria that may be considered when setting preferences based on local housing needs and priorities, as well as the process for establishing preferences.

   a) Assessing local housing needs. A PHA's system of local preferences must be based on local housing needs and priorities by using generally accepted data sources and information obtained through the PHA Plan public comment process[3]. HUD encourages PHAs to work collaboratively with health care providers, social service providers,

[3] 24 CFR 960.206(a)(1) for Public Housing and 24 CFR 982.207 (a)(2) for the HCV program.

homeless services providers, Continuums of Care (CoCs), and local offices of government and community organizations to establish a system of preferences based on local housing needs collectively identified by the community. HUD recommends that a PHA's local housing needs assessment specifically include people experiencing homelessness. For example, PHAs may look to their Community Plan to End Homelessness, Consolidated Plans, HIV/AIDs Housing Plan (if available) and/or data from their jurisdiction's Continuum of Care (CoC) Homeless Management Information Systems (HMIS) and Point in Time (PIT) Counts to identify whether and to what extent there is need for a homeless preference.

b) Applying and limiting preferences. PHAs may apply preferences for admission to the HCV, Project-based Voucher (PBV), and/or Public Housing programs, or to a particular public housing or project-based voucher development (or set number of units within a development). PHAs may limit the number of applicants that may qualify for a particular preference. PHAs must incorporate such a preference into their HCV program Administrative Plan and/or their Public Housing program Admission and Continued Occupancy Policy (ACOP). If adopting the preference constitutes a significant amendment to the PHA Plan as defined by the PHA, the PHA must comply with the amendment provisions of 24 CFR 903.21, including soliciting public comment and consulting with the resident advisory board.

c) Opening waiting lists and public notice. All recipients of public housing or HCV assistance must be selected from the PHA's waiting list(s). If a PHA does not have enough applicants on its waiting list who qualify for a preference, the PHA may open its waiting list strictly to people to whom the preference applies. When opening a waiting list, PHAs must give public notice. See Section 12 for more information on opening separate waiting lists for project-based voucher units.

Any public notice announcing a waiting list opening and application procedure should be simple, direct, and clear but with sufficient detail to inform applicants of the processes through which they can apply, any limitations on who may apply, and any other information the applicant may need to successfully submit the application. The notification process, as well as the preferences themselves, must also comply with HUD fair housing requirements, such as adopting suitable means to assure that the notice reaches eligible individuals with disabilities and those with limited-English proficiency. HCV program regulations require the public notice to appear in a local newspaper of general circulation, minority media, and other suitable means (24 CFR 982.206).These practices are strongly encouraged in the Public Housing program.

When trying to reach people experiencing homelessness to apply to the program(s), PHAs could consider reaching out to shelters, homeless service providers, agencies that work closely with people experiencing homelessness and homeless consumer advocacy groups to assist with advertising the opening of the waiting list, to seek referrals, and/or to provide assistance with application processes. The CoC Program interim rule requires Continuums of Care to establish and operate a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services with the intention of matching the homeless individual or family with the most appropriate resources. PHAs are strongly encouraged to participate in the coordinated assessment system that covers the PHA's geographic location in order to establish a means for referrals once the coordinated assessment has been established.

Once an adequate number of persons experiencing homelessness meeting the preference have been placed on the waiting list, the PHA may choose to close the waiting list. A PHA may leave the waiting list open only for the population qualified for the preference (i.e., continue to accept applications only from applicants that qualify for the preference) , while keeping it closed for all other applicants. HUD recommends the PHAs maintain up-to-date information on the PHA's website as to whether the waiting list is open or closed, who may currently apply for assistance, and specific information regarding the application process.

d) Identifying preference-qualified applicants currently on the waiting list. When adopting a new preference in the Public Housing program, PHAs must offer the opportunity for current applicants on the waiting list who qualify for the preference to receive the benefit of the preference and move up on the waiting list accordingly. This practice is strongly encouraged in the HCV program. The PHA should specify on any public notice of a waiting list opening that current waiting list applicants will also be given the benefit of the preference. The notice should also include any other information new applicants and current applicants on the waiting list will need to know about how to successfully apply and establish their preference status, including any partnering agencies with whom the PHA may be working to receive referrals or determine preference eligibility. PHAs and partnering referral agencies may consider sharing waiting list data in order to cross-check for eligible applicants, if allowed under applicable program requirements and privacy laws.

e) Limiting preferences to people referred by a partnering organization. PHAs may create a preference or limited preference specifically for people who are referred by a partnering homeless service organization or consortia of organizations (for example, an organization that refers people transitioning out of a shelter, transitional housing program, or rapid re-housing program). The PHA may not limit the source of referrals to an agency, organization, or consortia that denies its services to members of any Federally protected class under fair housing laws, *i.e.*, race, color, religion, national origin, sex, disability, or familial status. See section 12 of this Notice for information on preferences in the PBV program.

A PHA may also have a preference for individuals and families transitioning, or "moving up," from Permanent Supportive Housing (PSH) units. These are persons that were previously homeless prior to entry into the PSH program but who no longer need that level of supportive services. While these persons would not be considered homeless for reporting purposes on the Form HUD 50058, creating such a "move up" preference will contribute significantly to the community's overall efforts to end homelessness by freeing up units for currently homeless families and individuals with disabilities who need housing combined with services.

Example of a homeless limited preference process: A PHA limits the number of families that qualify for a homeless preference to 100 families. The PHA administrative plan/ACOP clearly states the criteria to qualify for the preference, including any partnering service agencies from whom the PHA will be taking referrals, and whether the preference is restricted to those referrals. The PHA opens the waiting list and provides public notice, but restricts who can apply to those that meet the preference criteria. Once the PHA is serving 100 families under the preference, and one family leaves the program, the next family on the waiting list who meets the preference criteria will be served. If there is no one on the waiting list that meets the preference criteria, the PHA would issue the voucher to the next family on the waiting list. The PHA reaches out to local partners for referrals, and the waiting list is kept open (or re-opened for applicants that qualify for the preference) in order to accept

these new referrals. If the PHA has not limited the preference to only people referred by certain organizations or agencies, then the PHA also accepts applications from anyone who self-identifies as qualified to meet the preference criteria.

f) Verifying preference eligibility. If a PHA adopts a preference or limited preference for people experiencing homelessness, or for a particular subset of this population, the PHA may require the individual or family to provide documentation to prove that they qualify for the preference, or may rely on a partnering homeless service organization (for example, the Continuum of Care designated collaborative applicant) to verify that the individual or family qualifies for the preference. When a PHA establishes a partnership for referrals from a homeless service organization, they may allow the partnering organization to verify the individual's or family's preference qualification, before the individual or family is referred to the PHA.

g) Ensuring Fair Housing compliance. When adopting a preference or limited preference for people experiencing homelessness, and opening the waiting list only for families and individuals that qualify for the preference, a PHA must ensure that the preference would not have the purpose or effect of excluding other eligible families from the program on the basis of race, color, national origin, religion, sex, disability, or familial status, or would have the effect of creating, increasing, or perpetuating segregation. A PHA must ensure that the adoption of a homeless preference and the opening of the waiting list, including site-based waiting lists, only to homeless families and individuals that qualify for the preference is done in a manner that is consistent with all fair housing and civil rights laws and affirmatively furthers fair housing.

h) Residency preference. PHAs that have a residency preference as allowed under the regulations at 24 CFR 960.206(b) and 24 CFR 982.207(b) may include in their definition of the term, "residence," shelters and other dwelling places where homeless people may be living or sleeping. PHAs may also consider the circumstances leading to a family's current dwelling place when defining residency for homeless applicants. For example, in some communities, there may be a lack of suitable shelters in the community covered by the PHA's residency preference forcing the family or individual to seek shelter in another community. If an applicant family or individual is residing in a shelter located outside of the area covered by the PHA's residency preference, the PHA may establish policies considering the applicant's previous residency and circumstances. PHAs with a residency preference may need to change their definition of residency in their Administrative Plan and ACOP for the purpose of allowing such flexibility.
For additional guidance related to waiting list administration, please see Notice PIH 2012-34 *Waiting List Administration.*

8. <u>Admissions Policies Regarding Criminal Activity, Substance Use/Abuse, and Rental History:</u> Under federal laws and HUD regulations, there are certain policies for admission to a PHA's HCV or Public Housing program which are mandatory for all PHAs, and other policies which the PHAs have authority/discretion to adopt, but are not required.

The following is a complete list of statutorily mandated prohibitions of admissions regarding criminal activity and substance use/abuse to the HCV and PH programs:

1. ***Lifetime sex offender registrant.*** A PHA **must** prohibit admission for any household that includes a person subject to a lifetime registration requirement under a State sex offender registration program.[4]

2. ***Methamphetamine production in federally assisted housing.*** A PHA **must** prohibit admission if any household member has ever been convicted of drug-related criminal activity for manufacture or production of methamphetamine on the premises of federally assisted housing.[5]

3. ***Within 3 years of federally assisted housing eviction for drug-related crime.*** A PHA **must** prohibit admission for three years from date of eviction if a household member has been evicted from federally assisted housing for drug-related criminal activity (the PHA **may** admit if the PHA determines the member successfully completed a supervised drug rehabilitation program approved by the PHA, or the circumstances leading to the eviction no longer exist).[6]

4. ***Currently engaged in illegal drug use or threatening activity.*** A PHA **must** prohibit admission of households with a member who:
    a. The PHA determines is currently engaging in illegal use of a drug,[7] or
    b. The PHA determines that it has reasonable cause to believe that a household member's illegal drug use, pattern of illegal drug use, abuse of alcohol, or pattern of abuse of alcohol may threaten the health, safety, or right to peaceful enjoyment of the premises by other residents.[8]

Where the HCV or public housing applicants' conduct or activities falls outside the scope of the statutorily mandated prohibitions, PHAs have wide discretion whether to admit or deny admissions to these individuals. Unfortunately, PHAs' discretionary admissions policies can sometimes be a barrier for vulnerable populations, including people who are homeless, to accessing the programs. For example, a PHA may have strict policies related to criminal backgrounds and previous rental housing history which can have the effect of screening out the most vulnerable people experiencing homelessness who are more likely to have past convictions, past evictions, or previous debts, due to a variety of reasons, including mental illness and substance use disorders.

In June 2011, Secretary Donovan wrote a letter to PHAs[9] across the country to encourage more flexible, reasonable admissions policies for people re-entering communities following incarceration. Incarceration and homelessness are highly interrelated as the difficulties in reintegrating into the community increase the risk of homelessness for released prisoners, and homelessness in turn increases the risk for subsequent re-incarceration. PHAs wishing to serve more people experiencing homelessness may consider amending their discretionary admissions policies regarding criminal activity and substance use/abuse to be more inclusive of vulnerable

[4] 42 U.S.C § 13663 (a); 24 CFR 982.553(a)(2)(i) for HCV, and 960.204(a)(4) for public housing

[5] 42 U.S.C § 1437n (f)(1); 24 CFR 982.553(a)(1)(ii)(C) for HCV, and 960.204(a)(3) for public housing

[6] 42 U.S.C § 13661 (a); 24 CFR 982.553(a)(1)(i) for HCV, and 960.204(a)(1) for public housing

[7] 42 U.S.C § 13661 (b)(1); 24 CFR 982.553(a)(1)(ii)(A) for HCV, and 960.204(a)(2)(i) for public housing

[8] 42 U.S.C § 13661 (b)(1); 24 CFR 982.553(a)(1)(ii)(B) and 24 CFR 982.553(a)(3) for HCV; 960.204(a)(2)(ii) and 960.204(b) for public housing

[9] http://portal.hud.gov/hudportal/documents/huddoc?id=sohudreentryltr.pdf

populations who may have criminal backgrounds or histories of incarceration. PHAs are encouraged to establish strong partnerships with homeless service providers to ensure that those vulnerable individuals and families admitted to the program are provided the services necessary to remain stably housed and compliant with the family obligations and other requirements of the program.

A PHA wishing to serve more people experiencing homelessness may consider reviewing their discretionary admission policies to determine if any changes can be made to remove barriers. It is important to note that all discretionary admission (and program termination) policies must be applied to all applicants broadly. In other words, a PHA cannot have a certain set of admission/termination policies that apply specifically to a certain population, such as the homeless population, which are different than the admission/termination policies for all other applicants, unless there is express legal authority to do so (e.g. HUD-VASH program). Therefore, if a PHA is not comfortable or willing to revise its general discretionary policies, the PHA is strongly encouraged to consider relevant circumstances as described in Section 10 of this Notice.

9. **Program Termination and Eviction Policies:** Federal law and HUD regulations provide only limited instances where a PHA must terminate assistance or evict a family[10]. Outside of those limited instances, PHAs or owners may terminate program assistance or evict a family only for serious or repeated violations of material terms of the lease. Many of the policies for termination of assistance and eviction are in fact at the discretion of the PHA or owner. A PHA or owner's discretionary policies for termination of assistance and eviction for lease violations is an important consideration in the effort to prevent homelessness.

   HUD encourages PHAs to review their termination and eviction policies in light of their discretionary authority. HUD recommends that PHAs work with homeless service providers to establish discretionary termination and eviction policies best suited to the community and to develop partnerships that can implement effective eviction prevention strategies.

   Additionally, PHAs should be aware of protections for victims of domestic violence, dating violence, or stalking to ensure that they do not face eviction because of the lease violations of their abusers. 24 CFR 5.2005 (c) states that an incident of actual or threatened domestic violence, dating violence or stalking will not be construed as a serious or repeated violation of the lease by the victim or threatened victim of the domestic violence, dating violence, or stalking, or as good cause to terminate the tenancy or, occupancy rights of, or assistance to the victim.

   As mentioned in Section 7 of this Notice, PHAs are encouraged to establish strong partnerships with healthcare, supportive services, and homeless service providers to make services available to vulnerable individuals and families admitted to the program. PHAs are also strongly encouraged to consider relevant circumstances when considering the termination or eviction of any family, as described in Section 10 of this Notice.

10. **Consideration of Circumstances Regarding Admissions and Terminations/Evictions:** As discussed in Section 7 of this notice, a PHA cannot establish separate admissions/termination

[10] 24 CFR 982.553(a)(2)(i), 24 CFR 982.553(b)(1)(ii) and 24 CFR.553(e) for HCV, and 24 CFR 960.204(a)(3) and 960.204(a)(4) for Public Housing

policies for a certain population, such as the homeless population, which are different from the admissions/termination policies for all other applicants, unless there is express legal authority to do so (e.g. HUD-VASH program). However, the public housing regulation at 24 C.F.R. 960.203(a) (Standards for PHA tenant selection criteria) and the HCV program regulation at 24 C.F.R. 982.552(c)(2) (Consideration of circumstances) imply that **individual consideration of factors** should be a basis for a PHA's decision to deny or terminate assistance. For example, in the HCV program, in determining whether to deny admission or terminate assistance because of an action of a family member that would normally screen the family out or cause the family to lose their assistance, under the PHA's policy, the following **may** be considered:

- All relevant circumstances such as the seriousness of the case, the extent of participation or culpability of individual family members, mitigating circumstances related to the disability of a family member, and the effects of denial or termination of assistance on other family members who were not involved in the action.[11]

- The PHA **may** impose, as a condition of admittance or continued assistance for other family members, a requirement that family members who participated in or were culpable for the action will not reside in the unit. The PHA **may** permit the other members of a participant family to receive or continue receiving assistance.[12]

In public housing, in the event of receipt of unfavorable information about an applicant, consideration **must** be given to the time, nature, and extent of the applicant's conduct (including the seriousness of the offense). Consideration **may** be given to factors which might indicate a reasonable probability of favorable future conduct, including: evidence of rehabilitation, and applicant's willingness to participate in social services.[13]

For both the HCV and Public Housing program, in determining whether to deny admission or terminate assistance for illegal use of drugs or alcohol abuse by a household member who is no longer engaged in such behavior, the PHA **may** consider whether such household member is participating in or has successfully completed a supervised drug or alcohol rehabilitation program or has otherwise been rehabilitated successfully.[14]

For both the HCV and Public Housing program, if the family includes a person with disabilities, the PHA decision regarding denial of admission or termination of assistance is subject to reasonable accommodation requirements in accordance with Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, Title II of the Americans with Disabilities Act, and their implementing regulations at 24 CFR part 8, 24 CFR part 100, and 28 CFR part 35, respectively.

11. <u>Service Provider as a Resource in Continued Occupancy:</u> Service providers are important resources in ensuring housing stability, including compliance with program and family obligations and other program requirements, for homeless individuals and families newly admitted to the program.

[11] 24 CFR 982.552(c)(2)(i) for HCV

[12] 24 CFR 982.552(c)(2)(ii) for HCV, and 960.203(c)(3)(i) for public housing

[13] 24 CFR 960.203(d)

[14] 42 U.S.C § 13661 (b)(2); 24 CFR 982.552(c)(2)(iii)

PHAs may establish working relationships or consider service agreements with the service providers to provide greater access to services for tenants. The PHA may consider making available an empty office space or community space for the service provider to offer voluntary services to the residents.

12. **Project-Based Vouchers:** Under the HCV program, PHAs are allowed to project-base up to 20 percent of their budget authority. Project-based vouchers (PBVs) are a useful tool in the development of affordable housing, because the guaranteed rental income provided by the vouchers helps to finance project operating costs and secure capital investments. PBVs are also important in the development of projects that pair services for people who are formerly homeless with housing assistance. PHAs looking to increase the supply of affordable housing for people experiencing homelessness or other low-income families may consider project-basing. PHAs interested in working with a homeless service provider to develop housing for people experiencing homelessness may also consider project-basing for this purpose.

    PHAs must select applicants for PBV units from the waiting list in accordance with the policies in the PHA administrative plan. The PHA may use a separate waiting list for its PBV units, or for PBV units in individual projects or buildings, or for sets of such units. The PHA may also adopt a different set of admissions preferences for each separate waiting list. A PHA that wishes to partner with a homeless service provider to project-base vouchers may consider creating a separate waiting list for this project and adopting a preference for people who are homeless. PHAs may also adopt a preference for services offered for families with disabilities that need services at a particular project. However, such a preference is limited to those individuals and families with disabilities that significantly interfere with their ability to obtain and maintain themselves in housing; who without appropriate supportive services, will not be able to obtain or maintain themselves in housing; and for whom such services cannot be provided in a non-segregated setting. See 24 CFR 983.251(d).

    If a PHA opens a site-based waiting list for PBV units, all new applicants and families or individuals currently on the PHA's tenant-based waiting list must be provided with the option to have their names placed on this list as well. As described in Notice PIH 2011-54, *Guidance on the Project-Based Voucher Program,* PHAs do not have to notify each family on the tenant-based waiting list by individual notice. A PHA could notify these applicants by the same means it would use in opening its waiting list under 24 CFR 982.206(a), including advertising through local and minority newspapers and the internet, posting at local post offices, libraries, and community center, and outreach to social service organizations, such as homeless shelters.

    Normally, PHAs may not provide project-based assistance to more than 25 percent of the number of units (assisted or unassisted) in a project. See 24 CFR 983.56(a). However, a PHA that makes units in a project available specifically to elderly or families with disabilities or families receiving supportive services ("excepted units") may exceed this 25 percent cap with these excepted units only. In these circumstances a PHA may place project-based vouchers in up to 100 percent of the units in the project.
    For units that are excepted because they are made available to elderly or disabled families, the PHA may not require participation in any type of services as a condition of tenancy, although services may be offered. For units that are excepted because they are made available to families receiving supportive services, a PHA may not require participation in medical or disability-related services other than drug and alcohol treatment in the case of current abusers as a condition of living in an excepted unit; however, other supportive services as defined by the PHA, including Family Self-

Sufficiency (FSS) services, may be required as a condition of tenancy. The PHA Administrative Plan must describe the type of services offered to these families or individuals for a project to qualify for the exception to the 25 percent cap and the extent to which the services will be provided. See 24 CFR 983.56(b).

Note: PHAs are reminded that PBV projects with up to 100 percent of the units committed to people with disabilities continue to be allowed under federal statute at 42 U.S.C. 1437(f)(o)(13)(D)(ii) and the HUD regulations cited above. On the services side, policy direction related to health reform implementation, behavioral health care integration, and state *Olmstead* planning will shape how services are defined, delivered, and financed for different populations. HUD recommends that PHAs establish strong relationships with state and county Medicaid authorities and health services agencies to discuss how Medicaid services might work in different housing settings and for different population groups going forward.

For more details related to Project-based Vouchers, please see Notice PIH 2011-54, *Guidance on the Project Based Voucher Program*.

13. **Paperwork Reduction Act:** The information collection requirements contained in this document have been submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520) and assigned OMB control number 2577-0083. In accordance with the Paperwork Reduction Act, HUD may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection displays a currently valid OMB control number.

14. **Information Contact:** Inquiries about this Notice should be directed to Ryan Jones at Ryan.E.Jones@hud.gov for Public Housing or Amaris.Rodriguez@hud.gov for Housing Choice Vouchers.

/s/

Sandra B. Henriquez, Assistant Secretary for
Public and Indian Housing

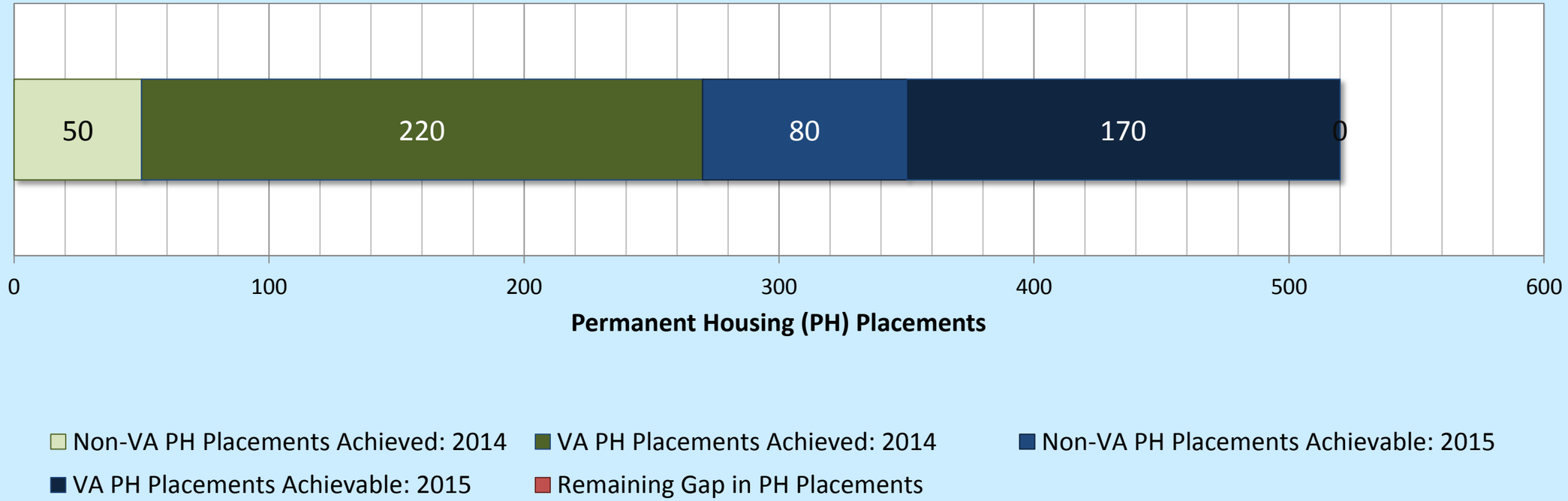
FY14 Q4 Veteran Homelessness Gaps Analysis Completed by VA Medical Centers November 2014

VHA Homeless Programs

V20/Alaska HCS

Progress towards ending Veteran Homelessness since Jan 2014 and effort remaining before end of Dec 2015

In 2014,	In 2015, VAMC and partners	VAMC and partners have the
VAMC and partners enabled	have the resources to enable	resources to meet needs of all
270 homeless Veterans	**250 homeless Veterans**	Veterans estimated to experience
to achieve permanent housing	to achieve permanent housing	homelessness between 2014-15



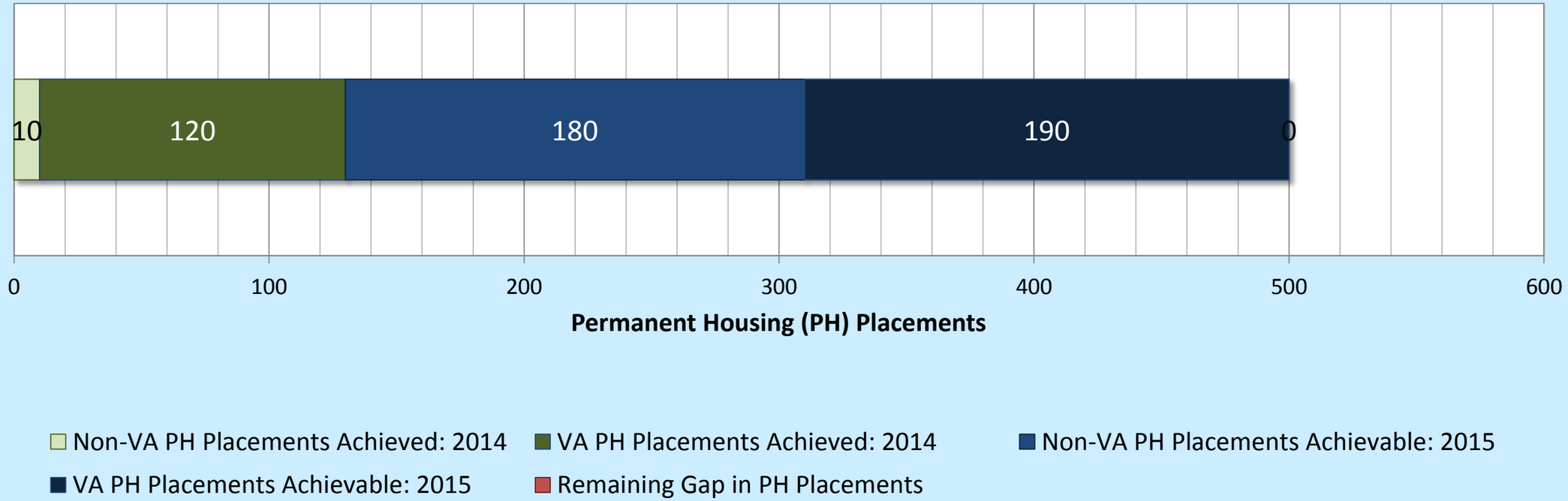
Produced on 1/16/2015. Data shown above is based on the FY14Q4 Veteran Homelessness Gap Analysis completed by this VA Medical Center in Nov 2014.

VHA Homeless Programs

V20/Boise

Progress towards ending Veteran Homelessness since Jan 2014 and effort remaining before end of Dec 2015

In 2014,	In 2015, VAMC and partners	VAMC and partners have the
VAMC and partners enabled	have the resources to enable	resources to meet needs of all
130 homeless Veterans	**370 homeless Veterans**	Veterans estimated to experience
to achieve permanent housing	to achieve permanent housing	homelessness between 2014-15



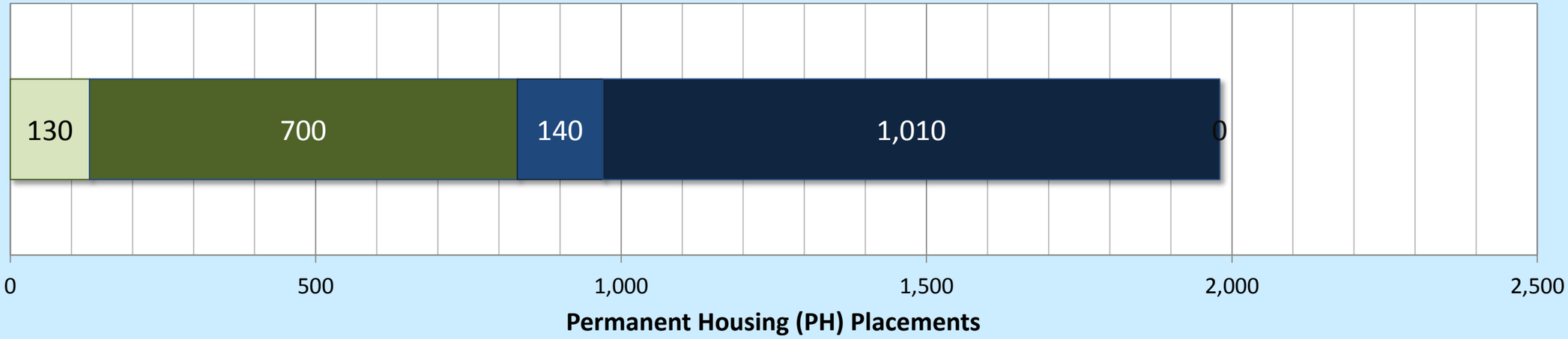
Produced on 1/16/2015. Data shown above is based on the FY14Q4 Veteran Homelessness Gap Analysis completed by this VA Medical Center in Nov 2014.

VHA Homeless Programs

V20/Portland

Progress towards ending Veteran Homelessness since Jan 2014 and effort remaining before end of Dec 2015

In 2014,	In 2015, VAMC and partners	VAMC and partners have the
VAMC and partners enabled	have the resources to enable	resources to meet needs of all
830 homeless Veterans	**1,150 homeless Veterans**	Veterans estimated to experience
to achieve permanent housing	to achieve permanent housing	homelessness between 2014-15



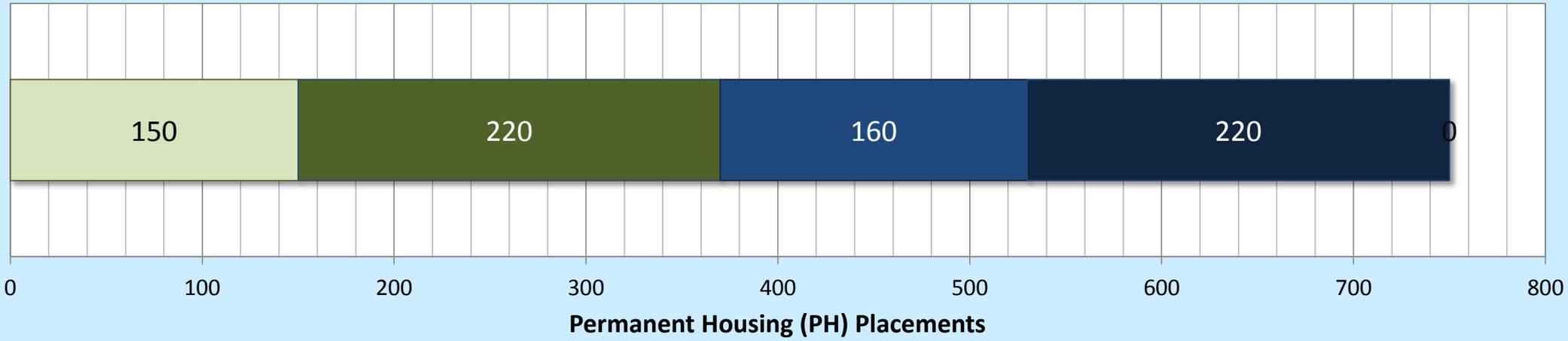
Produced on 1/16/2015. Data shown above is based on the FY14Q4 Veteran Homelessness Gap Analysis completed by this VA Medical Center in Nov 2014.

VHA Homeless Programs

V20/Roseburg HCS

Progress towards ending Veteran Homelessness since Jan 2014 and effort remaining before end of Dec 2015

In 2014,	In 2015, VAMC and partners	VAMC and partners have the
VAMC and partners enabled	have the resources to enable	resources to meet needs of all
370 homeless Veterans	**380 homeless Veterans**	Veterans estimated to experience
to achieve permanent housing	to achieve permanent housing	homelessness between 2014-15



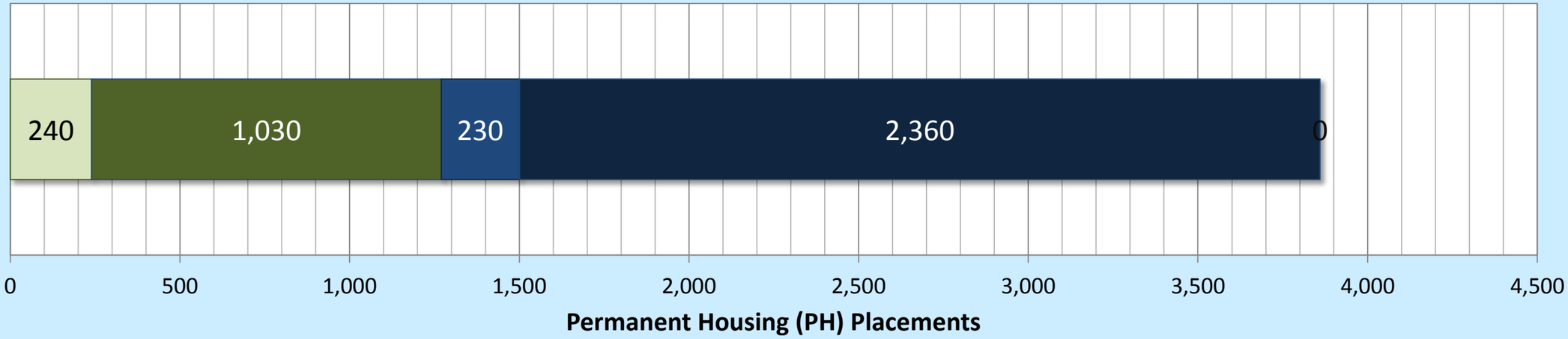
Produced on 1/16/2015. Data shown above is based on the FY14Q4 Veteran Homelessness Gap Analysis completed by this VA Medical Center in Nov 2014.

VHA Homeless Programs

V20/Seattle

Progress towards ending Veteran Homelessness since Jan 2014 and effort remaining before end of Dec 2015

In 2014,	In 2015, VAMC and partners	VAMC and partners have the
VAMC and partners enabled	have the resources to enable	resources to meet needs of all
1,270 homeless Veterans	**2,590 homeless Veterans**	Veterans estimated to experience
to achieve permanent housing	to achieve permanent housing	homelessness between 2014-15



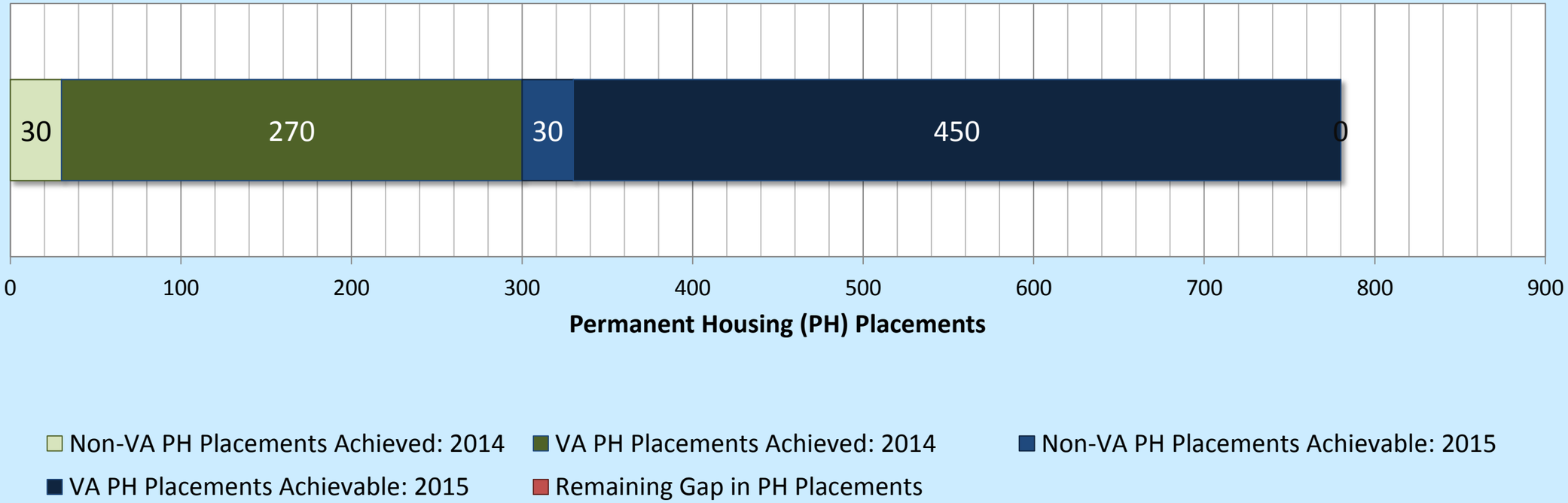
Produced on 1/16/2015. Data shown above is based on the FY14Q4 Veteran Homelessness Gap Analysis completed by this VA Medical Center in Nov 2014.

VHA Homeless Programs

V20/Spokane

Progress towards ending Veteran Homelessness since Jan 2014 and effort remaining before end of Dec 2015

In 2014,	In 2015, VAMC and partners	VAMC and partners have the
VAMC and partners enabled	have the resources to enable	resources to meet needs of all
300 homeless Veterans	**480 homeless Veterans**	Veterans estimated to experience
to achieve permanent housing	to achieve permanent housing	homelessness between 2014-15



Produced on 1/16/2015. Data shown above is based on the FY14Q4 Veteran Homelessness Gap Analysis completed by this VA Medical Center in Nov 2014.