CITY OF SWEET HOME COMMUNITY HEALTH COMMITTEE AGENDA

August 09, 2021, 6:00 PM
Sweet Home City Hall, 3225 Main Street
Sweet Home, OR 97386

WIFI Passcode: guestwifi
PLEASE silence all cell phones – Anyone who wishes to speak, please sign in.

Mission Statement

The City of Sweet Home will work to build an economically strong community with an efficient and effective local government that will provide infrastructure and essential services to the citizens we serve. As efficient stewards of the valuable assets available, we will be responsive to the community while planning and preparing for the future.

Meeting Information

The City of Sweet Home is streaming the meeting via the Microsoft Teams platform and asks the public to consider this option. There will be opportunity for public input via the live stream. To view the meeting live, online visit http://live.sweethomeor.gov. If you don't have access to the internet you can call in to 541-367-5128, choose option #1 and enter the meeting ID to be logged in to the call. Meeting ID: 861 388 18#

Call to Order and Pledge of Allegiance

Roll Call

Homeless Action Committee

a) Review Operating Procedures Proposed by FAC & Council Presentation

Adjournment

The location of the meeting is accessible to the disabled. If you have a disability that requires accommodation, advanced notice is requested by notifying the City Manager's Office at 541-367-8969.

Operations Manual Policies & Procedures March 2021

Contents

An Introduction to Family Assistance and Resource Group Linn County

Housing Instability in LinnCounty

An Overview of Family Assistance and Resource Group LinnCounty

The major components of Family Assistance and Resource Group LinnCounty include:

- Coordinated entry through the FAC Call Center and Street Outreach Team
- Coordinated screening and assessment using the Service Prioritization and Decision Assistance Tool (SPDAT)
- A Community Queue to prioritize households for housing and services based on vulnerability and severity of need
- Housing-Focused Emergency Shelter services, including centralized shelter bed management
- Counseling services to divert people from entering shelter or becoming street homelessness
- Resource Hub staffed by Navigation Coaches to rapidly re-house people who are literally homeless
- Transitional Housing for select populations, including transitional age youth, people fleeing abuse and violence at home, and people in early stages of substance abuse recovery, among others
- Connections to mainstream and community services, including child care, food security, physical, mental and behavioral health, employment and job training, public benefits access and veterans' services, among others

Family Assistance and Resource Group funders, service providers, landlords and community partners share a common agenda to improve the housing stability, economic security and health of people experiencing, or at imminent risk of, homelessness.

The ultimate goal of Family Assistance and Resource Group is to achieve a "functional zero" for housing and services in which the county's capacity to meet the needs of people experiencing or at imminent risk for homelessness exceeds the demand at any given time.

The Family Assistance and Resource Group Public-Private Partnership

FAC is a cross-sector collaboration between county agencies, nonprofit service providers, philanthropic foundations, landlords, faith organizations, homeless advocates, clients and other community partners committed to ending and preventing homelessness in Linn County.

Structure of the Family Assistance and Resource Group Operations Manual

The FAC Operations Manual is designed to provide information and guidance to Family Assistance and Resource Group service partners for the implementation of FAC program activities.
This document is aligned with and organized to follow the major processes of Linn County's unified housing crisis response system:
o Coordinated Entry, including Call Center and Street Outreach activities

o Housing Counseling
o Emergency Shelter
o Rapid Re-Housing
o Transitional Housing

The following information is included within each major process:
o **Guiding Principles**: Informed by best or promising practices in the field of homeless services, each section's Guiding Principles provide the policy foundation upon which Family Assistance and Resource Group's services are built. Family Assistance and Resource Group is aligned with principles, best practices, and policies promoted by *Opening Doors*, the federal strategic plan to prevent and end homelessness, the United States Department of Housing and Urban Development (HUD), the United States Inter-Agency Council, the National Alliance to End Homelessness, national thought leaders, scholars, and peer communities, among others.

Target Population: Describes the population that is engaged by the service or program; typically defined by the HUD Homeless categories used.
Major Steps: Describe the major procedures to be undertaken by FAC service providers within the component. Links to related policies and Program Guidance are included within the Major Steps so that users may easily find other relevant information.
Program Guidance: Provides additional information, tips, and strategies to FAC service providers on how to effectively carry out services related to the component. Program Guidance is meant to provide an additional, more thoughtful framework for making program-related decisions and carrying out the case management services in the manual.
Outcome and Output Measures: Outline program goals, and describe how programs and services will be evaluated for effectiveness.

Following these chapters outlining program procedures, the **Family Assistance and Resource Group Policies** then outline applicable policies across the major processes.
Finally, the FAC Operations Manual has multiple companion documents, all of which are available upon request to the Family Assistance and Resource Group Program Manager. These companion documents include:
• **Family Assistance and Resource Group Forms, Templates and Examples –** templates of all case management forms used by Family Assistance and Resource Group providers
• **Family Assistance and Resource Group Data Systems Policy & Procedure Manual –** policies & procedures related to HMIS use and data input
• **SPDAT (version 4) & F-SPDAT (version 2) Manuals –** outlining how to conduct the SPDAT

Coordinated Entry

Linn County residents experiencing homelessness or at-risk of becoming homeless call the Family Assistance and Resource Group number by dialing 541-224-7503 to access appropriate housing and services. Calls are answered by FAC who conduct screening and assessment and refer eligible callers to the Community partners for services. By centralizing intake and program admissions decisions, a coordinated entry process makes it more likely that families and individuals 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 people are referred to based on a comprehensive understanding of each program's specific requirements, target population, and available beds and services.

Guiding Principles of Coordinated Entry:

US Department of Housing and Urban Development. HUD Coordinated Entry Policy Brief, 2015.

• **Phased assessment-** The assessment tools are employed as a series of situational screenings and assessments that allow the assessment process to occur over time and only as necessary.

• **Necessary information**- The assessment process only seeks information necessary to determine the severity of need and eligibility for housing and services and is based on evidence of the risk of becoming or remaining homeless.

• **Participant autonomy**- The protocol for filling out assessment tools provides the opportunity for people receiving the assessment to freely refuse to answer questions without retribution or limiting their access to assistance.

• **Person-centered**- The assessment process provides options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need.

• **Cultural competence-** Staff administering assessments use culturally competent practices, and tools contain culturally appropriate questions.

• **User-friendly**- Tools are brief and effortlessly administered by non-clinical staff (including outreach workers), minimize the time required to utilize, and are easy for those being assessed to understand.

• **Privacy protections-** Privacy protections are in place to ensure proper consent and use of client information. See policy on Entering Non-Identifying Information into FAC Data Systems

• **Meaningful recommendations-** Tools are designed to collect the information necessary to make meaningful recommendations and referrals to available housing and services.

• **Written standards, policies and procedures-** The Continuum of Care for Family Assistance and Resource Group services has written standards describing who is prioritized for assistance and how much assistance they might receive. The policies and procedures governing the coordinated assessment process are approved by Family Assistance and Resource Group members and easily accessible to stakeholders in the community.

• **Sensitive to lived experiences-** Providers recognize that assessment, both the kinds of questions asked and the context in which the assessment is administered, can cause harm and risk to individuals or families, especially if they require people to relive difficult experiences. The tool's questions are worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people experiencing homelessness.

Target Population

Literally Homeless (HUD Homeless Category 1)	Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: 1. Has a primary nighttime residence that is a public or private place not meant for human habitation; 2. Is living in a 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 and local government programs); or 3. Is exiting an institution where (s)he has 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
Doubled-Up/ Couch-Surfing (HUD Homeless Category 2)	An individual or household temporarily living in the home(s) of others due to economic hardship and who must leave this housing situation immediately.
Living in a Hotel or Motel (HUD Homeless Category 2)	An individual or household living in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals.

Fleeing/ Attempting to Flee Domestic Violence (HUD Homeless Category 4)	Any individual or family who: 1. Is fleeing, or is attempting to flee, domestic violence; 2. Has no other residence; and 3. Lacks the resources or support networks to obtain other permanent housing
Homeless Prevention for Veterans	An individual or household who: □ Is a veteran, as defined as "a person who served or is serving in the active military or air service." □ Imminently at-risk of literal homelessness but for SSVF assistance

Major Steps

1. Pre-Screen for housing crisis

Persons experiencing homelessness, or their advocates, contact FAC 541-224-7503.
FAC follows the Call Center Script (Form 1.1) to complete the initial screening for basic eligibility for FAC services.

- Callers reporting domestic violence are offered the DV Hotline at 1-800-642-3150. Or CARDV 541-
- Callers who are veterans and in a housing or homeless crisis are immediately eligible.
- Callers that do not meet basic eligibility for FAC services are referred to appropriate community-based resources.
- Callers who are reaching FAC during night or weekend hours will be given referral information based on the policy for after-hours.

For callers that meet the basic eligibility, the FAC contact will read the Family Assistance and Resource Group Consent Statement (Form 1.2) to the caller to determine the appropriate level of personally-identifying information to be entered into the client mgmt system. Callers that choose to not share their personally-identifying information, including victims of Domestic Violence, are entered into the system following the policy on Entering Non-Identifying Information into FAC Data Systems.
The Navigator creates the profile for the Head of Household and for all other family members. The Navigator links the household members in CMS.

2. Provide Diversion

- The FAC Navigator will continues to follow the Call Center Script (Form 1.1) to provide emergency shelter and homeless diversion services.
- Call Center Navigator will explore natural resources available to the caller to help them self-resolve their housing or homeless crisis and offer support in utilizing those natural resources as appropriate.
- Call Center Navigator will utilize motivational interviewing techniques to help the caller problem solve and use their own strengths and resources to find other safe, alternative housing solutions.
- Call Center Navigator will offer referrals to community resources related to income, employment, education, child care, transportation, health care, or others as appropriate to help divert the household from utilizing emergency shelter.
- Callers will be informed of Family Assistance and Resource Group program and service eligibility and prioritization as outlined in Coordinated Entry Program Guidance.

If the caller can identify safe, alternative housing options, the Call Center Navigator will provide community resources as appropriate and end the call. A service record and note will be entered into CMS to reflect the outcome of the conversation.

3. Assess using the FAC Referral Assessment and VI-SPDAT

If diversion is unsuccessful, the Call Center Navigator continues to follow the Call Center Script (Form 1.1) and starts a new FAC Referral Assessment for the head of household in CMS using the appropriate household type (family, youth, or single).

- The Call Center Navigator completes the full assessment with the caller.
- The Call Center Navigator refers any Category 1 homeless callers directly to the Street Outreach Team via CMS. o Any Category 1 homeless caller who is a veteran is referred directly to the SSVF Outreach Team via CMS.
    - Any Category 1 homeless caller who is in an emergency shelter will be referred to the Community Queue for Rapid Re-Housing via CMS.
- Any caller reporting Category 1 homelessness but refusing to complete the FAC Referral Assessment (or engage further with the Call Center Specialist) will be referred directly to the Street Outreach Team via CMS, following the policy on callers refusing to complete an assessment. In these instances, the Call Center Navigator should use active listening techniques to accommodate the client who does not wish to further engage in the assessment part of the call. Through clear communication of Family Assistance and Resource Group's services and prioritization policies, the caller will be encouraged to participate in the assessment so as to receive Family Assistance and Resource Group services. However, if the caller continuously refuses, the Call Center Navigator will engage with the client as much as possible to ascertain the location of the client, a way to contact the client, and a way to engage with the client (e.g., an exact location of where the client sleeps at night or visits during the day; a phone number for the client; the make, model, location, color and, if possible, the license plate number of the car they sleep in). This information will be passed along in the Street Outreach referral.
- The Call Center Navigator refers any veteran in need of homelessness prevention directly to the Homeless Prevention SSVF Program via CMS.
- The Call Center Navigator refers any couch surfing/doubled up household directly to the Community Queue to receive Housing Counseling.
- The Call Center Navigator refers any household living in a hotel that is not being paid for by a charitable or government organization to the Community Queue to receive Housing Counseling.
- The Call Center Navigator refers any household in other circumstances to the Family Assistance and Resource Group Program Manager or other community resources as appropriate, as outlined in Family Assistance and Resource Group Crisis Cases.

The Call Center Navigator will inform the caller of their VI-SPDAT score, eligibility for programs, and timeline for a call back from a Family Assistance and Resource Group provider, as outlined in the Family Assistance and Resource Group Call Center Script (Form 1.1), Coordinated Entry Program Guidance, Client Assessment and Screening Policies and Prioritization Policies.

The Call Center Navigator will provide any other local community resources as appropriate and end the call, informing the caller to call the call center back if they have not heard from a provider within the timeframe provided, or if their situation changes.

4a. Verify street homelessness

Upon receipt of a referral for a person who reports street homelessness, the Street Outreach Team or SSVF Outreach Worker (for veterans) contacts the client and updates the status of the Referral Record to "Pending-In Process".

- The Street Outreach Team denies any referrals that they are unable to contact after 2 attempts within 48 hours. These referrals do NOT get sent back to the Community Queue.

The Street Outreach Team sets up an outreach meeting with persons reporting street homelessness, and updates the Referral Record notes in CMS to reflect the meeting date, time and location.

- Meetings will take place in the location where the person is reporting to sleep at night, as soon as possible.
- The Street Outreach Team meets in-person to verify that the individual/ household's primary nighttime residence is a place not meant for human habitation.
- The Street Outreach Team enrolls the client into the Street Outreach program in CMS as soon as an in-person meeting is held.

    - If a person does not show up to the meeting, the Referral is denied and is NOT sent back to the Community Queue.

The Street Outreach Team engages in interview and assessment to confirm that the person's primary nighttime residence is a place not meant for human habitation.

- Once a determination is made, the Street Outreach Team:
    - o Updates the Program Enrollment page to reflect the person's homeless history.
    - o Updates the FAC Referral Assessment to either Confirm or Deny street homelessness, and reason for denial.
- Family Assistance and Resource Group Street Outreach refers to the community queue via CMS as appropriate.

4b. Assess needs of street homeless persons and connect to shelter

For those that are confirmed as street homeless, the Street Outreach Team assesses the client's needs and access to shelter based on their knowledge of system resources. This includes:

- Reviewing the Shelter Current Housing Availability Report and contacting Shelter Directors via email to confirm current openings. o If beds/ units are available, the Street Outreach navigator will close the Street Outreach Program Enrollment after the household is enrolled in shelter.
- Referring single adults to non-Family Assistance and Resource Group Partner shelters.
- Assessing clients for appropriateness for shelter/ congregate living due to medical need.
    - The Street Outreach navigator contacts the local Housing Resource Center if the client has medical needs that would fall under the Emergency Hotel Assistance Policy.

The Housing Resource Supervisor approves or denies the request; see Crisis Case A: Coordination of Emergency Hotel Stay.

The Street Outreach navigator identifies other service needs.

- If other service needs are identified, the Street Outreach navigator will provide referral information for appropriate services and conduct follow-up with the client.

The Street Outreach navigator will keep the Street Outreach Program Enrollment "Open," or "Active" on their caseload, until a referral destination is determined and/or the Street Outreach navigator 's assessment and referral activities are ended, as outlined in the policy on Street Outreach Caseload. At that time, the Street Outreach navigator will close the Street Outreach Program Enrollment in CMS.
The Street Outreach navigator will ensure that the client is referred to the Community Queue for appropriate services.

5. Refer to the Community Queue for triage

The Street Outreach navigator refers all persons directly to the Community Queue or Veterans Programs via CMS after updating the appropriate information on the FAC Referral Assessment.

- Households confirmed as literally homeless by Street Outreach will be referred to the Community Queue for Rapid Re-Housing and/or Emergency Shelter.
- Households not confirmed literally homeless by Street Outreach will be referred to the Community Queue for Housing Counseling as appropriate.

Crisis Case A: Coordination of Emergency Hotel Stay

For street homeless clients identified as qualifying for a subsidized hotel stay under the Emergency Hotel Assistance Policy:

- Street Outreach/ Emergency Shelter Director will contact the nearest HRC Supervisor for hotel subsidy.
- The HRC Supervisor will approve or deny the request according the Emergency Hotel Assistance Policy.
- If approved, the HRC Supervisor will use the referral functionality in CMS to "reassign" the client to their agency's Pending Queue.
- The client is enrolled into the appropriate program at the HRC.

If not approved, the Street Outreach navigator will ensure that the client is referred to the Community Queue for shelter.

- If the client is in need of a hotel stay past 30 days, the HRC supervisor will then reach out to the Family Assistance and Resource Group Program Manager for approval of continued funding for hotel stay.

Crisis Case B: Referral to Office of Jackson Street Youth by Call Center

For households with children under the age of 18 reporting to the Call Center that the children are Category 1 homeless or will be Category 1 homeless that night, with no other presenting concerns regarding abuse or neglect:

- The Call Center Navigator will first follow the process for referring toJackson Street Youth group for confirmation of street homelessness.
- The Call Center Navigator will call the 24-hour Family Assistance and Resource Group Street Outreach program phone line to report to the street outreach team that a family is reporting that children are sleeping outside or will be sleeping outside that night.
- The Call Center will then log notes into the client's profile in CMS to document the call and discussion.

The Family Assistance and Resource Group Street Outreach team will process the referral and follow up with the family immediately, collaborating with Linn County Mobile Crisis Service as appropriate.
The Family Assistance and Resource Group Street Outreach team and/or the Linn County Mobile Crisis Service team will call the OfficeJackson Street Youth intake office directly and make a formal childline report if the following conditions are met:

- The children are confirmed as sleeping in a place not meant for human habitation.

- There is no immediate emergency shelter available for the family that night.
- It has been established that there is no safe place for the children to reside temporarily until shelter space is available.

Jackson Street Youth administrator will email the Family Assistance and Resource Group Program Manager directly to provide follow-up and case coordination the next business day.
The Street Outreach team will connect the family to emergency shelter when it becomes available.
If there is any concern for child safety that necessitates an immediate response, the police should be contacted as outlined in the Jackson Street Youth Policy.

Crisis Case C: Coordination of Institutional Discharges to Homelessness

For individuals being discharged from a public institution directly to homelessness, who meet the definition of Category 1 Homeless and who are within 14 days of their discharge date from the institution:

- Institution Social Workers/Case Managers will assist individuals in calling the Family Assistance and Resource Group Call Center to complete the Screening and Assessment.
    - A referral will be sent directly to Street Outreach
- Family Assistance and Resource Group Street Outreach will contact the individual and the institution social worker to discuss homelessness status and verification of homelessness prior to entering institution.
- Family Assistance and Resource Group Street Outreach will also assess if the individual can be safely and appropriately accommodated in a congregant living environment.
    - If Street Outreach verifies that an individual was literally homeless prior to entering the institution, the individual has been in the institution for less than 90 days, *and* the individual can be safely accommodated in an emergency shelter, Street Outreach will update the Family Assistance and Resource Group Referral Assessment in CMS and refer the individual to emergency shelter through CMS. Entry into shelter will be based upon Family Assistance and Resource Group's Prioritization Policy.
    - If Street Outreach is unable to verify literal homeless status, or if the individual cannot be safely accommodated in an emergency shelter, Street Outreach will notify the institution social worker to contact the Family Assistance and Resource Group Program Manager for a Case Coordination Conference Call. The Street Outreach referral will be denied at that time.
- If a patient does not meet Federal Criteria of homelessness but needs special consideration, or if Street Outreach denies the referral, Institution Social Workers/Case Managers may arrange a Case Coordination Conference Call including, at a minimum,
    - Institution Social Worker/Case Manager
    - Family Assistance and Resource Group Program Manager and/or Housing Resource Center Supervisor
    - Coordinated Homeless Outreach Center Shelter Director and/or Street Outreach navigator Case Manager
    - Others as appropriate: Mental Health Service Providers (Access Services Case Worker; Recovery Coach/ ACT Team; Magellan Care Manager; representative of Linn County Department of Behavioral Health/ Developmental Disabilities); Aging and Adult Services; Veteran's Services; etc.
- During the Case Coordination Conference Call, all service partners will discuss a housing and supportive services plan for the individual that includes:

    - Emergency housing assistance plan to resolve the immediate crisis
    - Supportive services plan to provide the type and level of supports needed to keep the client safe and healthy
- Follow-up timeframe to develop a long-term housing plan once the immediate crisis is resolved

Crisis Case D: Linn County Code Blue

The Department of Public Safety is responsible for recommending Code Blue emergencies to the County Commissioners during periods of extreme, life-threatening weather, defined as a wind-chill factor of 20°F or below. Code Blue declarations will be issued for a specific duration, usually based on 24-hour increments, and will end as initially declared unless formally extended by the County Commissioners. During these times of a declared Code Blue:

- Households in need of shelter will 541-224-7503 the FAC Call Center
    - Call Center navigator will screen for Linn County residency as outlined in the Family Assistance and Resource Group Policy on County Residency
- Any caller reporting being a resident of another county will be encouraged to utilize emergency shelters in their counties of origin
    - Call Center navigator will conduct a FSC Referral Assessment with the caller if it is during FAC Call Center hours.

 If household is calling after FAC hours, 2-1-1 navigator will make a note in the internal 2-1-1 database and verbally provide referrals.

- Call Center navigator will inform the caller that it is a declared Code Blue night and that they can present to their nearest emergency shelter for temporary shelter.
- On the next business day, FAC Street Outreach will follow up with the caller in order to conduct outreach. Once engaged with outreach, the street outreach case manager will enter the household's information & FAC Referral Assessment into CMS if one has not already been completed.
- Emergency shelter case managers will enroll the household into Code Blue Emergency Shelter program when the household presents to shelter within 1 business day
    - ES Case Manager to end enrollment of Code Blue or Seasonal/Overflow program once Code Blue is complete and household has left shelter. If household will be staying in shelter past declared Code Blue days, ES Case Manager must end enrollment of Code Blue program enrollment and enroll household in the regular ES Program.
- ES Case Manager to ensure that household is connected withFAC by completing/updating a FAC Referral Assessment *and* ensuring that the household is referred to appropriate services & programs through CMS once Code Blue is complete.
- If Code Blue Emergency shelters reach maximum capacity on declared Code Blue nights, a Family Assistance and Resource Group provider (e.g., an emergency shelter monitor or case manager;
- a 2-1-1 navigator) will call the Family Assistance and Resource Group Street Outreach program at 541-224-7503.
- Following Policy 1.21, the Family Assistance and Resource Group Street Outreach provider may approve a temporary hotel subsidy for street homeless households during declared Code Blue nights. In these instances, the Street Outreach director will make a final determination of the approval of a hotel subsidy based on case knowledge of the household, knowledge of the lack of

shelter availability, and an assessment of the household's need. When approved, hotel subsidy will only cover the time period when there is a declared Code Blue.

- If approved, Street Outreach will arrange the hotel stay and follow up next business day. Upon the completion of Code Blue and the hotel subsidy, Street Outreach will continue to engage, ensuring the household is connected to all services and programs through Family Assistance and Resource Group as appropriate.

Program Guidance

Acuity and Service Interventions in Family Assistance and Resource Group

Family Assistance and Resource Group's housing crisis response system is based on the practice of matching the service intervention provided to clients with their level and depth of needs. This is similar to how doctors are matched to patients in an emergency room- a patient having a heart attack is matched with a cardiologist who has received specific training to address and treat heart conditions. A patient with a broken arm is matched with an orthopedic doctor, who has been trained to set broken bones.

Similarly, FAC matches clients to specific types of housing and support interventions based on the depth of their needs, called their "acuity level". Acuity is the presence of specific barriers that have been proven to affect a household's ability to maintain housing. Acuity is determined through completion of Family Assistance and Resource Group's common assessment tool, the Service Prioritization and Decision Assistance Tool (SPDAT) or its shortened counterpart, the Vulnerability Index- SPDAT (VI-SPDAT). There are three levels of acuity that are determined by the SPDAT - high acuity (high needs/ vulnerability/ barriers), medium acuity, and low acuity. For more on the SPDAT and acuity, please review the SPDAT Manual, available by request.

FAC service providers use the results of the SPDAT assessment to determine the appropriate service intervention for the client:

• High acuity households are matched with intensive supportive services and deeper and longer rental subsidies. The ideal intervention is Permanent Supportive Housing, which has no term limit on the length of time to receive supports and subsidy.

• Medium acuity households are matched with temporary supports and rental subsidies. The ideal intervention is Rapid Re-Housing, which is typically provided for 3- 24 months (with an average of 6-9 months).

• Low acuity households are matched with fewer supports and one-time subsidies. The ideal intervention is case management to help the household self-resolve or one-time financial assistance to help them end their homelessness.

Acuity Level, Service Intervention, and VI/SPDAT Score Range			
Household Acuity	**Ideal Intervention in Family Assistance and Resource Group**	**SPDAT Score Range**	**VI-SPDAT Score Range**
High Acuity	Permanent Supportive Housing	Individuals: 35-60 Families: 54-80 Youth: 35-60	Individuals: 8+ Families: 9+ Youth: 8+
Medium Acuity	Rapid Re-Housing	Individuals: 20-34 Families: 27-53 Youth: 20-34	Individuals: 4-7 Families: 4-8 Youth: 4-7
Low Acuity	Case Management or One-Time Financial Assistance	Individuals: 0-19 Families: 0-26 Youth: 0-19	Individuals: 0-3 Families: 0-3 Youth: 0-3

Vulnerability and Prioritization for Services

Family Assistance and Resource Group's goal is to reach a "functional zero" for housing and services, in which the county's capacity to meet the needs of people experiencing or at imminent risk for homelessness exceeds the demand at any given time. In practice, this would mean that any household that becomes homeless would be matched with the appropriate level of support and subsidy within 30 days of becoming homeless.
FAC has not reached that goal yet- demand exceeds the capacity to provide all levels of service (Permanent Supportive Housing, Rapid Re-Housing, and Housing Counseling). As a result, FAC must prioritize who it serves first when resources don't allow us to serve everyone.

FAC 's prioritization policies are based on the principle of serving the most vulnerable clients first. This is similar to how an emergency room triages patients- the patient having a heart attack is served before the patient with the broken arm, even if the patient with the broken arm has been waiting longer. Under FAC , this means that higher acuity clients are served first, and oftentimes more quickly, than lower acuity clients.
As well, clients in very high-risk situations may be prioritized for services over others with a higher acuity. This is the case for street homeless clients with significant medical or mental health needs, who may be connected to a Housing Resource Center immediately to provide emergency assistance. As a result, Housing Resource Centers may not always be able to predict exactly when they can schedule their next intakes for Rapid Re-Housing, or they may need to "bump" scheduled intakes in order to address the high-risk client's needs.

Effect on clients and Advocates

Family Assistance and Resource Group's limited resources and its prioritization policies result in the fact that some clients who are relatively lower in acuity will not receive services in a timely manner. We are continually working to improve this, but in the meantime, this reality can present real challenges and frustrations for clients, FAC service providers, community partners, and client advocates.

Communicating Prioritization Policies: Info for FAC Service Providers

Explaining why clients may not receive certain services, or that they may be waiting a long time to receive those services, is a real and understandable challenge for FAC provider staff, community partners,
and client advocates. In addition to the information above, FAC providers, community partners, and client advocates should use the following framework, messages and strategies to explain the prioritization process to clients if questions arise:
clients have a right to know about their access to resources within FAC . clients should always be told their assessment score and how this relates to supports and housing interventions available through FAC .
At the Call Center, the Call Center Navigator will inform the client of the results of the Screening, the caller's program eligibility, the caller's VI-SPDAT score, the service intervention they will receive first (Street Outreach or Housing Counseling), and an approximate timeframe in which they will receive a call back (see Policy 1.9 Screening, Assessment, and Referral Information Provided to Callers)
Timeframe for call back (based on current response rates):

- Street homeless should expect a call from the Street Outreach navigator within 1-4 days.
- Households referred to Housing Counseling with a high acuity VI-SPDAT score (individuals: 8+ families: 9+) should expect a call from a Case Manager within 5 business days.
- Households referred to Housing Counseling with a medium acuity VI-SPDAT score (individuals: 4-7 families: 4-8) should expect a call from a Case Manager within 7-14 business days.
- Households referred to Housing Counseling with a low acuity VI-SPDAT score (individuals: 0-3 families 0-3) should expect a call from a Case Manager within 14 business days.

More information on Screening Results and Assessment Results can be found in the Call Center Script *(Form 1.1) and* Family Assistance and Resource Group Referral Assessment *(Form 5.33)*.
In a shelter, the Case Manager will complete the SPDAT assessment with the client and share how the results of the assessment inform the type of housing intervention and supports they can be referred to. In these conversations, Case Workers should:

- Emphasize the areas of strength and resources that the client already has, and how these can be used to obtain housing on one's own.
- Explain that subsidized housing is not available unless the client has already been approved for the Housing Authority's waiting list.
- Explore the cost of living and develop a budget for living on one's own. Assess this in terms of the client's current income.
- Explain that one-time assistance may be available to move into a unit that is affordable.
- Explore other options for housing based on the client's income and resources.

More detailed information on housing planning by SPDAT score is provided under the Emergency Shelter Program Guidance *section.*

Communicating Prioritization Policies: Info for FAC Community Partners and Advocates

Community partners and client advocates can help clients understand Family Assistance and Resource Group's process by reinforcing FAC 's messaging and contacting the FAC Program Manager directly for assistance when needed. Additional strategies and guidance are below:

Community partners and advocates should review the Operations Manual policies and procedures on Coordinated Entry and Prioritization. Reinforcing the intent and process for prioritization will help provide a consistent message to clients and the larger community. Partners can contact the Community Relations Manager directly if they would like additional assistance in understanding policies and procedures and how to message this information to clients or their own community networks.

Community partners should request information from the client about their SPDAT score and review the notes and assessment information in CMS (if they have access) prior to contacting the Program Manager or a FAC service provider directly. Community partners without access to CMS should obtain a signed Release of Information form for Housing and Community Development if they do not have CMS access and wish to discuss the client's score with the Program Manager.

Community partners and client advocates can use the information in the Program Guidance above to explain how the SPDAT score relates to housing support through FAC . If assistance is needed that falls within the scope of what FAC may provide to the client, and the client has been denied these resources, community partners and advocates are encouraged to contact the Family Assistance and Resource Group Program Manager directly.

Community advocates working with clients who are waiting to receive FAC services should contact the FAC Program Manager directly to check in on the client's prioritization level and anticipated timeframe for receiving services.

Community partners/ client advocates should not contact the Housing Resource Center staff directly if a client has not been seen for intake yet by that HRC, or to advocate for a higher prioritization level for their client.

The FAC Program Manager will provide a best estimate of the timeframe in which a client will be connected to housing supports.

The FAC Program Manager may recommend that other options be pursued if the wait time is anticipated to be longer than 60 days.

Output and Outcome Measures

The following measures will be used to evaluate the performance of the FAC Coordinated Entry process:

- Number of unduplicated callers calling in to the Call Center
- Number/ Percentage of callers reporting street homelessness, imminent risk of homelessness, and living in unstable housing
- Number/ Percentage of callers referred to FAC services (Housing Counseling, Street Outreach)
- Number/ Percentage of persons reporting street homelessness who are verified as such
- Average days to confirm street homelessness
- Average days from call to shelter entry for street homeless individuals
- Average days to contact Housing Counseling clients

- Average days on Community Queue (for street homeless, for imminent risk, for persons waiting for Rapid Re-Housing appointment)

Policies Family Assistance and Resource Group Service Provider staff are encouraged to become familiar with all Family Assistance and Resource Group Policies.
The Family Assistance and Resource Group Policy sections listed below provide guidance and direction for the implementation of FAC Coordinated Entry services.

1. Client Assessment and Screening Policies
2. FAC Prioritization Policies
3. Street Outreach Policies

Housing Counseling

Emergency Shelter Case Workers and Housing Resource Center Housing Stability Coaches provide Housing Counseling to assist clients in resolving their housing crisis and assist with the development of a Housing Counseling plan that is actionable, client-directed, and time- limited.
Housing Counseling helps families and individuals on the brink of homelessness to develop plans to avoid entering a shelter or living on the street. By doing so, the service reduces costly system interventions like emergency shelter, and frees limited shelter resources for those who have no other option. Since FAC began providing Housing Counseling in a coordinated manner, as many as 80% of households enrolled in the service have been successfully diverted from entering homeless shelters.

Guiding Principles of Housing Counseling

• **Entering emergency shelter is traumatic for individuals and families.** Therefore, preventing as many families and individuals, especially children, from entering shelters is an important step in reducing the trauma experienced by people in our community.

• **Emergency shelter is an expensive and scarce resource that must be preserved for those who have no other options.** Emergency shelters have operated at full or overflow capacity for many years, and as such, there is no space available for persons who are street homeless to immediately be sheltered. By preserving shelter space for those who truly need it, the community can more effectively work towards the goal of providing shelter immediately to those in crisis.

Target Population

Doubled-Up/ Couch-Surfing	An individual or household temporarily living in the home(s) of others due to economic hardship and who must leave this housing situation immediately.
Living in a Hotel or Motel	An individual or household living in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals.

Major Steps

1. Complete intake and enrollment

Emergency Shelter Program Supervisors use the referral functionality in CMS to “re-assign” referrals directly from the Community Queue to their shelter’s Pending Queue when shelter space is available, so long as there are no households who are immediately eligible for emergency shelter and a priority. The referral is assigned an emergency shelter case worker to provide Housing Counseling.

Housing Resource Center Supervisors use the referral functionality in CMS to “re-assign” referrals directly from the Community Queue to their HRC’s Pending Queue, and then assign referrals to Housing Stability Coaches as case load space is available.
The Case Worker/Housing Stability Coach contacts the candidate and updates the referral status to Pending- In Process.

- The Case Worker/Housing Stability Coach denies any referrals that they are unable to contact after at least 2 attempts within 48 hours. These referrals are NOT sent back to the Community Queue.
- Upon engagement, the Case Worker/Housing Stability Coach enrolls the client into the Housing Counseling program in CMS.

2. Provide Housing Counseling case management

The Case Worker/ Housing Stability Coach provides case management over the phone to the client to develop a plan to prevent the client from entering shelter, if possible.
 The Case Worker/ Housing Stability Coach will read the FAC Call Center Verbal Consent statement (Form 1.2) to obtain verbal consent to enter basic service information into CMS. If consent is not provided, the Case Worker will mark the Program Enrollment as “Private” and all case notes as “Private”.

- The Case Worker/ Housing Stability Coach may use the Housing Counseling Program Guidance for resources on how to engage in this conversation with the client.
- The final goal of the conversation is to develop a safe, appropriate plan that will enable the client to maintain housing without entering a shelter or becoming street homeless.

If safe, appropriate options are identified to divert the household from entering shelter, the Case Worker/Housing Stability Coach works with the client to create a Housing Stability Plan (verbally or in-person) and to implement the steps outlined in the Plan.

- If one-time assistance from FAC is needed to complete the Plan, the Case Worker/ Housing Stability Coach must:
    - Ensure that the client meets the eligibility criteria for Housing Counseling financial assistance as defined in the policy on Financial Assistance for Housing Counseling.
    - Meet in-person with the client to sign the Housing Stability Plan and collect documentation of the client’s eligibility for financial assistance.
    - Collect all required documentation for payment prior to processing.
    - To provide financial assistance to Housing Counseling clients, • Housing Resource Center staff will process financial assistance following the Housing Resource Center Invoicing Policies.

• Shelter Case Workers will first collect all documentation required according to the Housing Resource Center Invoicing Policies, then will contact the FAC Program Manager for referral to the Housing Resource Center to make payment.

If the client is age 60 or older and may need nursing home care, protective services involvement, or a Level of Care assessment for nursing home services, contact the Office of Aging and Adult Services using the procedures described here.

3. Close the case: Client and Case Worker agree on a plan

If the client can be diverted from emergency shelter, the Case Worker/Housing Stability Coach exits the client from the Housing Counseling program in CMS.
 Note: Destination at Exit will be the actual location of the client to denote a successful discharge.

 Note: Housing Status at Exit will be At Risk of Homelessness.

If no safe, appropriate alternative to shelter can be identified:

- Shelter case workers will:
  - Exit the client from the Housing Counseling Program,
  - Offer shelter space/ shelter intake to the client,
  - Enroll the entire household into the Emergency Shelter Program when the household enters the shelter.
- Housing Stability Coaches will:
  - Create a **new** FAC Referral Assessment to update the client's information/ SPDAT, and show that the Result of Housing Counseling was Not Successful- Referring to Shelter.
  - Refer the client to the Community Queue for Emergency Shelter by sending a new referral directly to the Community Queue.
  - Continue to engage at least weekly with the household and keep the Housing Counseling program enrollment open until shelter space has been identified. If contact is lost for more than 2 weeks, the program enrollment can be closed, indicating "whereabouts unknown."
  - Review the Shelter Bed Availability Report and contact shelter directors directly via phone or email regarding shelter openings. The Housing Stability Coach may also coordinate and collaborate with Street Outreach regarding shelter placement prioritization.
  - Once a household has entered shelter, the Housing Stability Coach will exit the household from the Housing Counseling program.
- In both cases, the Destination at Exit will be Emergency Shelter, and the Housing Status at Exit will be Literally Homeless.

Shelter Program Supervisors will assign referrals from the Community Queue when shelter space is available and there are no other eligible households who can be directly admitted into shelter. Housing Resource Center Supervisors will assign referrals from the Community Queue to their staff as space is available.

Program Guidance

Flow of a Housing Counseling Conversation

Introduction: Case Worker/Housing Stability Coach introduces him/herself and asks the client to describe their current housing situation.

- Active Listening: Paraphrase what the client said.
  - Be empathetic- include their emotions/ feelings in the retelling
  - Maintain a non-judgmental tone
- Strength Exploration: Ask questions to explore past strengths.
  - Ask questions about when the client has been a help to others in the past
  - Begin to identify networks/ supports that may help the client maintain housing or income

Explore Options: Case Worker/Housing Stability Coach revisits what has been shared to explore potential options that are safe and appropriate.

- Diversion options may be apparent or the case manager may have to review supports again to identify options.
- Walk through reality-testing decisions with the client to further evaluate options.

Develop the plan: Case Worker/ Housing Stability Coach reviews what has been discussed with the client to develop a reality-tested plan.

One-Time Financial Assistance with a Housing Counseling Client

Most households receiving Housing Counseling will not need financial assistance to be diverted from shelter. Through clear communication of FAC 's prioritization policies, our target population of those experiencing literal homelessness, and/or the Emergency Shelter waitlist, most households receiving Housing Counseling should be encouraged to participate in the development of a safe permanent housing plan that does not require financial assistance. However, some households may need some limited financial assistance in order to successfully maintain permanent housing for a period up to 30 days, as determined through their Housing Counseling planning sessions with their case manager. As with other FAC programs, case managers are expected to use Progressive Engagement, relying first on the client's own resources and networks, and then use the least amount of system resources while developing a safe plan. Case Managers and/or Housing Stability Coaches should first explore low-cost, creative solutions to preventing entry into emergency shelter that are reimbursable through the FAC Initiative Fund. Examples of this might include car repair costs so a doubled-up family member can start driving to work; food gift cards to contribute towards staying at a friend's house; or bus tokens to attend a local vocational program or appointments with the commerce department.

If it is determined through Housing Counseling that the only way to avoid entry into shelter and/or literal homelessness is through one-time move-in assistance to rapidly re-house someone at imminent risk into their own permanent housing, the Housing Stability Coach and/or Case Manager should consult with their supervisor to approve the use of funding available to permanently house this client. The supervisor should base their approval of rapidly re-housing someone at imminent risk of homelessness based upon the availability of funding, the client's vulnerability as assessed through the VI-SPDAT, the latest research & best practices related to preventing someone from experiencing literal homelessness, and other individualized contributing factors. If move-in assistance is approved, all required documentation, forms, and policies related to receiving One-Time Financial Assistance is required.

Output and Outcome Measures

The following measures will be used to evaluate the performance of the FAC Housing Counseling program:

- Number of households enrolled in Housing Counseling services
- Number/ Percentage of households successfully diverted from entering shelter
- Number/ Percentage of households referred to or connected to mainstream and community resources

Policies

FAC Service Provider staff are encouraged to become familiar with all Family Assistance and Resource Group Policies.

The Family Assistance and Resource Group Policy sections listed below provide guidance and direction for the implementation of FAC Housing Counseling Services.

2. Prioritization Policies
4. Housing Counseling Policies

Emergency Shelter

Family Assistance and Resource Group Emergency Shelter programs empower families and individuals experiencing homelessness to regain permanent housing as quickly as possible while providing a safe place to sleep and housing-focused case management services.

Guiding Principles of Emergency Shelter

• **Prioritization of Emergency Shelter beds-** People who are literally homeless should be prioritized for shelter bed access.

• **Shelter entry-** Shelter entry should be fast, uniform, culturally sensitive, and low barrier for any resident experiencing homelessness.
• **Reduced length of stay-** Living in shelter is traumatic for families/individuals and costly to the housing crisis response system, meaning length of stay in shelter should be as short as possible.
• **Exit to permanent housing-** The majority of people experiencing homelessness can and should exit from emergency shelter directly to permanent housing.
• **Intervention and other supports-** Families and individuals are more responsive to intervention and social service support once in permanent and stable housing.

Target Population

Literally Homeless (HUD Homeless Category 1)	Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: 1. Has a primary nighttime residence that is a public or private place not meant for human habitation; 2. Is living in a 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 and local government programs); or 3. Is exiting an institution where (s)he has 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	
At Imminent Risk of Homelessness (HUD Homeless Category 2)	Individual or family living in the home of another or in a hotel not paid for by a charitable organization who will imminently lose their primary nighttime residence, provided that:	• Residence will be lost within 14 days of the date of application for homeless assistance; • No subsequent residence has been identified; and • The individual or family lacks the resources or support networks needed to obtain other permanent housing
Fleeing/ Attempting to Flee Domestic Violence (HUD Homeless Category 4)	Any individual or family who is fleeing, or is attempting to flee, domestic violence; • Has no other residence; and • Lacks the resources or support networks to obtain other permanent housing	

Major Steps

1. Receive referrals and conduct intake and enrollment

The FAC Program Coordinator distributes a weekly Shelter Current Housing Availability Report generated from CMS to all Emergency Shelter Directors, the FAC Program Manager, the Street Outreach navigator , and the Call Center.
Emergency Shelter Directors must ensure that the data contained in the report is correct and update the data within one business day if it is incorrect.

Upon review of the Shelter Current Housing Availability Report, emergency shelter managers will re-assign referrals to the Emergency Shelter Pending Queue from the Community Queue if shelter space is available. Upon re-assigning a referral for Emergency Shelter, the Case Worker contacts the client and updates the referral status to Pending- In Process. The Case Worker will collaborate with any current supports working with the individual, such as Street Outreach, in order to make contact with the eligible household.
The Case Worker denies any referrals that they are unable to contact after at least 2 attempts within 48 hours. Case Workers provide basic intake to candidates over the phone, based on the Emergency Shelter's intake and enrollment procedures.
For procedures related to intake & enrollment during declared Code Blue, reference Crisis Case D.

2. Provide a safe place to sleep

The Case Worker and Emergency Shelter staff provide sleeping arrangements and meals, and ensure client safety according to FAC and the Emergency Shelter's policies and procedures.

3. Assess for needs and develop Housing Stability Plan

The Shelter Case Worker will meet in-person to assess for needs and develop a Housing Stability Plan with all shelter clients residing in shelter longer than 5 days.

- Case Workers will complete the following with the client:
    - Household Budget (Form 5.16)
    - Service Prioritization and Decision Assistance Tool (SPDAT)
    - Housing Stability Plan (Form 5.10) Case Workers are encouraged to use the Program Guidance on Housing Stability Planning with Shelter Clients while developing these plans.

- Case Workers will upload a copy of all 3 documents into the client's CMS profile (for CMS-participating shelters).
- Case Workers will create a publically viewable note that contains a summary of the meeting and housing plan (for CMS-participating shelters).

Case Workers will develop Housing Stability Plans that contain the following at a minimum:

- **Housing Goals-** Concrete plan and action steps for moving to housing other than the shelter, ideally to permanent housing.
- **Financial Goals-** Goal and action steps related to obtaining all public/ mainstream benefits to which the client is entitled, and obtaining or maintaining income, possibly through education, employment, job training and/or financial counseling.
- **Health Goals-** Goal and action steps related to obtaining needed physical, mental and/or behavioral health services and supports.

Case Workers will work with clients regularly, meeting in-person at least weekly, to execute the action steps and goals outlined in their Housing Stability Plan.

- Case Workers will record progress, completion of action steps, and other notes on the Housing Stability Plan during in-person meetings.
- Case Workers will create a new Housing Stability Plan whenever new goals or action items are established.
- Case Workers will record all meetings and changes in CMS: o A summary of all case management meetings will be entered in the client's notes section. These may be marked Private if they contain medical information, per the Case Note Sharing policy.
    - A Status Assessment update will be noted whenever a client's income, benefits, health documentation status, or health services change.

4. Connect to permanent housing

For low acuity clients, the Case Worker will:

- Follow the Program Guidance on Housing Stability Planning for Shelter clients.
- Collect the required documentation for payment of costs to move the client out of shelter, following the policies on Move-Out Assistance for Households in Shelter and Eligible Activities/ Payments for Households in Shelter.
- Once all documentation is collected, contact the FAC Program Manager for referral/ connection to a Housing Resource Center to process payment.
- Assist in finalizing payment and move-out procedures for the client.

For clients who are medium acuity, the Case Worker will:

- Follow the Program Guidance on Housing Stability Planning for Shelter clients.
- After completing the Housing Stability Plan, make a referral to the Community Queue for Rapid Re-Housing: o In the household's CMS profile, under the "Assessments" tab, click "Edit" button next to the most recent FAC Referral Assessment. (Note: If the latest FAC Referral Assessment is over 30 days old, a new FAC Referral Assessment can be completed.)
    - Scroll down to the bottom of the FAC Referral Assessment. Click "In Emergency Shelter." Hit Save.
    - Return to the "Assessments" tab, click "Eligibility" button next to the FAC Referral Assessment.
    - Click "Refer directly to the Community Queue" button to complete the RRH referral for the client.
    - Add notes regarding the client's needs and click Send.
- The Case Worker will continue to execute the Housing Stability Plan action steps with the client. o The Case Worker will upload all relevant case planning documentation (initial and updated Housing Stability Plans, budgets, SPDAT's, etc) to the client's profile in CMS so that these documents are readily accessible for review by the Housing Stability Coach.
    - The Case Worker will maintain updated notes in CMS that provide accurate and complete information regarding the client's housing situation and status in shelter.
- The Case Worker will coordinate the connection to permanent housing if/ when the client is enrolled into the Rapid Re-Housing program. o The Case Worker will attend intake and other meetings with the client and Housing Stability Coach.
    - The Case Worker will provide all documentation and case planning information to the Housing Stability Coach.
    - The Case Worker will assist in creating and carrying out the steps of the client's Rapid Re-Housing Housing Stability Plan. The Case Worker will continue weekly case management with the client to follow up with/ support the completion of the Rapid Re-Housing Housing Stability Plan as appropriate.
- The Case Worker will keep the Housing Stability Coach informed of the client's progress on meeting action steps.
- The Case Worker will keep the Housing Stability Coach informed of the client's location and eligibility for the program, and inform the Coach within 1 business day if the client does not sleep in the shelter for more than 2 nights in a row.

For clients who are high acuity, the Case Worker will:

- Follow the Program Guidance on Housing Stability Planning for Shelter clients.
- After completing the Housing Stability Plan, make a referral to the Permanent Supportive Housing Committee for Permanent Supportive Housing: o Complete the referral paperwork and collect the required documentation.
    - Email information to the Office of Mental Health Community Housing Coordinator.

- If a bed/ unit for Permanent Supportive Housing is not available within the next 30 days, the Case Worker will make a referral to the Community Queue for Rapid Re-Housing: o In the household's CMS profile, under the "Assessments" tab, click "Edit" button next to the most recent FAC Referral Assessment. (Note: If the latest FAC Referral Assessment is over 30 days old, a new FAC Referral Assessment can be completed.)
    - Scroll down to the bottom of the FAC Referral Assessment. Click "In Emergency Shelter." Hit Save.
    - Return to the "Assessments" tab, click "Eligibility" button next to the FAC Referral Assessment.
    - Click "Refer directly to the Community Queue" button to complete the RRH referral for the client.
    - Add notes regarding the client's needs and click Send.
- The Case Worker will continue to execute the Housing Stability Plan action steps with the client.
- The Case Worker will upload all relevant case planning documentation (initial and updated Housing Stability Plans, budgets, SPDAT's, etc.) to the client's profile in CMS so that these documents are readily accessible for review by the Permanent Supportive Housing Prioritization Committee and/or the Housing Stability Coach.
- The Case Worker will maintain updated notes in CMS that provide accurate and complete information regarding the client's housing situation and status in shelter.
- The Case Worker will coordinate the connection to permanent housing if/ when the client is enrolled into Permanent Supportive Housing or the Rapid Re-Housing program. o The Case Worker will attend intake and other meetings with the client and PSH Case Worker/ Housing Stability Coach.
- The Case Worker will provide all documentation and case planning information to the PSH Case Worker/ Housing Stability Coach.
- The Case Worker will assist in creating and carrying out the steps of the client's Rapid Re-Housing Housing Stability Plan. ? The Case Worker will continue weekly case management with the client to follow up with/ support the completion of the Rapid Re-Housing Housing Stability Plan as appropriate.
- The Case Worker will keep the Housing Stability Coach informed of the client's progress on meeting action steps.
- The Case Worker will keep the Housing Stability Coach informed of the client's location and eligibility for the program, and inform the Coach within 1 business day if the client does not sleep in the shelter for more than 2 nights in a row.

Note that Case Workers should be applying the practices of progressive engagement with all clients, and should develop Housing Stability Plans that rely first on the client's own resources and networks, and then use the least amount of system resources needed to move the client to permanent housing. Acuity should be used as a general guide for case planning, but referrals should be informed through all assessment work and case management completed with the client. See Program Guidance on Housing Stability Planning for Shelter Households and Policy on Overriding the SPDAT Score Guidance for more guidance on this topic.

5. Close the case

Upon exit from shelter, the Case Worker will close out all agency paperwork according to agency procedures.
The Case Worker will exit the household from the Emergency Shelter program in CMS.
The Program Supervisor or Manager will re-assign shelter referrals from the Community Queue when bed space is available.

Program Guidance

Emergency Shelter Bed Prioritization

When there is insufficient emergency shelter capacity to meet the need of households experiencing homelessness in LinnCounty, shelter admission should be reserved for unsheltered households who are at greatest risk for severe health and safety consequences, as assessed by the FAC Street Outreach team who are in constant contact with these households. Therefore, when an emergency shelter will have an opening, shelter

providers are to contact the Street Outreach team directly to discuss the households on the Community Queue for emergency shelter in order to receive outreach's guidance and assessment related to which household should be prioritized. FAC strongly encourages daily, ongoing collaboration and communication between providers in order to serve those most in need.

Street Outreach and shelter providers must also follow these guiding principles related to prioritization of emergency shelter beds:

• FAC should continue to prioritize Category 1, street homeless households for entry into shelter
• FAC should use an open and transparent process for referring people to shelter
• FAC should prioritize certain populations for limited shelter space rather than prioritization based on a first-come, first-served basis
• FAC should not use the score from the VI-SPDAT as criteria to determine emergency shelter prioritization. The VI-SPDAT was not intended for this purpose and was developed to make recommendations for Rapid Re-Housing, Permanent Supportive Housing, and light touch housing interventions
• The complex needs, configurations, and situations of families and individuals who are experiencing street homelessness should be assessed and addressed by FAC 's trauma-informed, comprehensive homeless street outreach team
• Homeless families with a pregnant head of household should be prioritized for family shelter due to the serious health consequences associated with being unsheltered
• Homeless individuals with health diagnoses that lead to frailty should be prioritized for single adult emergency shelter due to the potential for health consequences associated with being unsheltered

For Housing Counseling households who are referred to shelter: Housing Counselors and Housing Stability Coaches are encouraged to keep open communication with the street outreach team regarding any household who isn't able to be diverted and is in need of emergency shelter, especially if that household needs to be a priority based on your initial assessment.

Housing Stability Planning for Households in Shelter

Emergency shelters are expected to create a Housing Stability Plan with each household in shelter that outlines the household's goals and action steps for obtaining permanent housing as quickly as possible, based on the household's SPDAT score and the financial assistance available to them.

Low Acuity Households Households scoring in the low acuity category on the SPDAT are encouraged to develop a Housing Stability Plan that utilizes the household's own resources and networks to gain permanent housing.

Shelter Case

Managers are encouraged to use motivational interviewing, housing-focused case management, and progressive engagement strategies to assist households in identifying ways in which they can move out of shelter and into permanent housing; similar to the strategies used during Housing Counseling.

Housing Stability Planning for low acuity clients will be unique to each household; however, it may result in the following types of plans:

• **Moving to safe doubled-up situations-** In many cases, households simply do not earn enough to live on their own. In these cases, moving (back) in with friends or family is a reasonable option to gain housing stability. Shelter Case Managers should ensure that the household's Housing Stability Plan addresses the factors that led to the household seeking shelter in the first place- such as building conflict resolution skills through counseling services, accessing mental health services, obtaining subsidized childcare, connecting to employment services, etc.
• **Moving to an affordable unit-** In some cases, households may earn enough income to live on their own, but lack the funds or support to initially obtain a unit. Shelter Case Managers must ensure that the Housing Stability Plan includes a household budget, including guidelines on rental prices, utility expenses, and other logistics needed to make housing successful and the budget balance. As well, the Housing Stability Plan should include housing search and location services to the extent needed by the household. Shelter Case Managers will then

assist clients in locating affordable units. Alternatively, shelter Case Managers can connect with the Housing Locator at the local Housing Resource Center to access additional housing location assistance once the Housing Stability Plan is completed.

• **Moving out of county to permanent housing-** In rare cases, households may need or want to move outside of LinnCounty in order to obtain permanent housing or to reconnect with their support networks. Shelters should ensure that Housing Stability Plans address the logistics of moving out of county, and address the factors that led to the household's homelessness.

Medium Acuity Households Households scoring in the medium acuity category on the SPDAT are encouraged to develop a Housing Stability Plan that first utilizes the household's own resources and networks to gain permanent housing, but that also identifies Rapid Re-Housing as a back-up plan for moving to permanent housing. Shelter Case Managers are encouraged to use motivational interviewing, housing-focused case management, and progressive engagement strategies to assist households in identifying ways in which they can move out of shelter and into permanent housing; similar to the strategies used during Housing Counseling.

When developing Housing Stability Plans for medium acuity households, shelters should help households consider:

• **The household's own resources and networks to gain permanent housing-** Some households may have housing options available to them, such as returning to doubled-up housing options. For some households, this may be more appropriate than moving into a unit of their own. This is particularly true of fixed income households or those waiting to receive benefit determinations (such as those waiting on SSI/SSDI applications or appeals). Shelter case managers are encouraged to have open conversations with these households about rent costs and their current income, and the time-limited nature of the Rapid Re-Housing program. If doubling up or room sharing is an option for these households, it may be more appropriate to develop a Housing Stability Plan for this option rather than referring to Rapid Re-Housing.

• **Preparing for Rapid Re-Housing intake and housing search-** Households eligible for Rapid Re-Housing should begin working with their shelter Case Manager to prepare for their first intake appointment with the Housing Stability Coach. This includes compiling and preparing the needed documents, working through the household's budget, identifying apartment needs/ logistics for the family, and ensuring that all current benefits are being accessed. Shelter Case Managers should share a copy of the Housing Stability Plan and the clients' progress on it with the Housing Stability Coach once the appointment is scheduled. This way, clients can transition more easily to the Rapid Re-Housing program and both Case Managers are up to date on the client's case.

• **Identifying potential barriers to obtaining housing-** Shelter Case Managers can help clients prepare for Rapid Re-Housing by helping to identify elements of a client's history that may make obtaining housing more difficult, so these can be mitigated if possible and/or discussed with the Housing Stability Coach and Locator at the first intake appointment. Barriers may include: recent criminal history, a history of eviction, outstanding utility debts, very poor or no credit, no income, large family size with no income, lack of transportation.

• **The household's needed supports, such as mental health, physical health, public benefits, childcare, etc-** While in shelter, households should be developing plans to connect to all benefits and supportive services necessary to maintain permanent housing.

High Acuity Households Households scoring into the high acuity category on the SPDAT should be referred to Permanent Supportive Housing (PSH), as this is the most appropriate intervention for this group. Shelter case workers follow the PSH Referral Policies to refer clients to PSH.

In the event that a PSH bed is not immediately available (i.e. within the next 30 days), the shelter Case Manager should develop a Housing Stability Plan that includes connection to Rapid Re-Housing as a temporary solution to move the household out of shelter and into permanent housing until PSH becomes available.

When developing Housing Stability Plans for high acuity households, shelters should help households consider:

• **Preparing documentation for PSH eligibility screening-** Households eligible for Permanent Supportive Housing should begin working with their shelter Case Manager to prepare the documentation needed for the PSH referral packet and documentation standards. Shelter workers should compile and submit all referral packet information as defined in the PSH Referral Process and related policies.
• **Secondarily, if PSH is not immediately available, prepare for their first intake appointment with the Housing Stability Coach from Rapid Re-Housing-** This includes compiling and preparing the needed documents, working through the household's budget, identifying apartment needs/ logistics for the family, and ensuring that all current benefits are being accessed. Shelter Case Managers should share a copy of the Housing Stability Plan and the client's progress on it with the Housing Stability Coach once the appointment is scheduled. This way, clients can transition more easily to the Rapid Re-Housing program and both case managers are up to date on the client's case.
• **Identifying potential barriers to obtaining housing-** Shelter case managers can help clients prepare for housing placement by helping to identify elements of a client's history that may make obtaining housing more difficult, so these can be mitigated if possible. Barriers may include: recent criminal history, a history of eviction, outstanding utility debts, very poor or no credit, no income, large family size with no income, lack of transportation.
• **The household's needed health supports, such as Critical Time Intervention, Recovery Coaching, Peer Support, physical services, and similar-** The shelter Case Manager should connect any client with a mental health diagnosis (or suspected diagnosis) directly to the CTI team and/or to the local Community Base Service Unit for assessment and services.
• **The household's needed other supports, such as SSI/SSDI Outreach, Access, and Recover (SOAR), other public benefits, childcare, etc-** While in shelter, households should be developing plans to connect to all benefits and supportive services necessary to maintain permanent housing. If a good candidate, shelter Case Managers should refer households to the FAC SOAR Navigator at VNA Community Services.

Output and Outcome Measures

The following measures will be used to evaluate the performance of the FAC Emergency Shelter program:

- Utilization rate of shelter beds
- Number of persons/ Households served in shelter (by household composition)
- Average length of stay in shelter
- Number/ Percentage of persons exiting to permanent housing
- Number/ Percentage of adults connected to non-cash benefits at exit

Policies

Family Assistance and Resource Group Service Provider staff are encouraged to become familiar with all FAC Policies.
The Family Assistance and Resource Group Policies listed below provide guidance and direction for the implementation of FAC Emergency Shelter services.
2. Prioritization Policies
5. Emergency Shelter Policies
6. Case Management Tools and Assessment Policies

Rapid Re-Housing

LinnCounty residents who are living on the streets, in an emergency shelter, or have been placed temporarily in a motel by a charitable or government organization are referred to the Rapid Re-Housing (RRH) program. HRC Housing Stability Coaches utilize RRH assistance and Housing First strategies to help those with a medium level of service needs find permanent housing and remain stably housed in their community by connecting to other, long-term community supports.

Rapid Re-Housing is an intervention designed to help individuals and families to quickly exit homelessness, return to housing in the community, and not become homeless again in the near term. The core components of Rapid Re-Housing are 1) housing identification, 2) move-in and rent assistance, and 3) case management and services.

Guiding Principles of Rapid Re-Housing

• **Inclusivity and flexibility-** Rapid Re-Housing is an intervention designed for and flexible enough to serve anyone not able to exit homelessness on their own. Rapid Re-Housing programs should not attempt to screen out households based on a score on an assessment tool or criteria that are assumed, but not shown, to predict successful outcomes, such as a minimum income threshold, employment, absence of a criminal history, evidence of "motivation," etc.

• **Progressive Engagement-** A Rapid Re-Housing program should make efforts to maximize the number of households it is able to serve by providing households with the financial assistance in a progressive manner, providing only the assistance necessary to stabilize in permanent housing.

• **Finding and maintaining permanent housing-** Within the limits of the participant's income, a Rapid Re-Housing program should have the ability to help households access units that are desirable and sustainable—those that are in neighborhoods where they want to live in, that have access to transportation, are close to employment, and that are safe.

• **Landlord engagement and retention-** Housing identification efforts should be designed and implemented to actively recruit and retain landlords and housing managers willing to rent to program participants who may otherwise fail to pass typical tenant screening criteria.

Target Population

Literally Homeless (HUD Homeless Category 1)	Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: 1. Has a primary nighttime residence that is a public or private place not meant for human habitation; 2. Is living in a 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 and local government programs);
or 3. Is exiting an institution where (s)he has 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	

Major Steps

1. Receive referral and conduct intake and enrollment

The Housing Resource Center Supervisor will re-assign referrals from the Community Queue to their Housing Resource Center's Pending Queue as case load space is available. The Housing Resource Center Supervisor will then assign a Housing Stability Coach (HSC) to each referral.

Upon receiving an assignment for referral, the HSC contacts the client and updates the referral status to Pending-In Process.

- The HSC will deny any referrals that they are unable to contact after at least 2 attempts within 48 hours. These referrals are NOT sent back to the Community Queue.

The HSC meets with the client for intake and enrollment.

- The HSC schedules the meeting at the emergency shelter with client and Shelter Case Manager; or in a mutually-agreed upon location if the client is not in shelter.
- The HSC will assist the client in completing the appropriate intake paperwork, gather eligibility documentation as outlined in the policy on Rapid Re-Housing Eligibility for New Clients and confirm eligibility by completing the Certification of Eligibility Form (Form 5.20).
- The HSC completes the SPDAT and Monthly Budget (Form 5.16) with the client.
- The HSC reviews the Program Agreement (Form 5.29), Client Rights and Responsibilities (Form 5.4), and Grievance Procedures (Form 5.3) in detail with the client, and both parties sign the Agreement. A copy is provided to the client.
- The HSC explains the process for obtaining housing through the program, and agrees with client on appropriate rent ranges based on:
    - Fair Market Rent and/or local housing costs
    - Client's current and projected income
    - Client's utility debts (if any) that may affect their ability to pay for utilities in own name

The HSC creates a Housing Stability Plan (Form 5.10) with the client outlining action steps and follow-up timeframe for both the client and HSC.

- The Housing Stability Plan must include at a minimum: o **Housing Goals-** Concrete plan and action steps for moving to housing other than the shelter, ideally to permanent housing. Rent ranges, logistics, and other housing location parameters must be included.
    - **Financial Goals-** Goal and action steps related to obtaining all public/ mainstream benefits to which the client is entitled, and obtaining or maintaining income, possibly through education, employment, job training and/or financial counseling.
    - **Health Goals-** Goal and action steps related to obtaining needed physical, mental and/or behavioral health services and supports.

The HSC enrolls the household into the Rapid Re-Housing Program in CMS.
The HSC creates a hard copy file for the client.

2. Locate housing

The Housing Stability Coach (HSC) provides the Housing Locator with the client's contact information, rent ranges, a copy of the Housing Search Planner (Form 5.8) and other basic information as appropriate.

The Housing Locator contacts the client to provide assistance in beginning housing search:

- Explains process, expectations, and role of Housing Locator
- Provides support/ orientation to housing search: o Completes the Housing Planner (Form 5.8) with the client with input from the HSC.
    - Provides Housing Search Tips (Form 5.9) handout to the client.
    - Provides Housing Search Log (Form 5.7) handout to the client.
- Reviews housing preferences and discusses guidelines for location, size, cost, and other amenities.
- Assesses the household's need for additional support in housing search.

The Housing Locator and client visit units to conduct visual inspection and agree on a unit.

The Housing Locator educates prospective landlords about the Rapid Re-Housing program, the FAC Landlord Engagement Fund, and answers any questions to encourage the landlord to rent to the client.

Once a client is approved for a unit, the Housing Locator begins the unit approval process.

- The Housing Locator orders an inspection (Form 5.11) by contacting Lynda Haley at the LinnCounty Housing Authority via email at lhaley@montcoha.org.
    - o The Housing Locator provides a copy of the inspection form to the landlord at least 5 days in advance of the scheduled inspection.
    - The Housing Locator receives an emailed confirmation and completed form with the results of the inspection.
    - If a unit fails inspection, the Housing Locator may work with the Landlord to fix the problems identified. Or, the Housing Locator may move on to another unit.

The Housing Locator assembles/ completes other documentation needed to demonstrate eligibility of the unit and maintains documentation in the client's file:

- Conducts a tax lien search at www.taxclaim.montcopa.org, prints out the form showing the tax lien search results and includes it in the client file.
- Requests a W-9 (Form 5.32) from landlord.
- Housing Locator completes the Rent Reasonableness Form (Form 5.24).

3. Provide move-in assistance

Once a unit is approved, the Housing Locator initiates the lease-signing.

- The Housing Locator contacts the landlord to negotiate costs for rent and move-in.
- The Housing Locator and Housing Stability Coach complete the Rental Agreement for Move-In letter (Form 5.26) with the client. A copy is provided to the client. o To calculate the client's contribution to move-in costs and rent in the first three months of move-in, a Rent Calculation Worksheet (Form 5.35) must be completed, as supported by the policy on Client Contributions to Housing Costs.
- The HSC completes the check request for move-in costs.

The Housing Locator assists the client with move-in logistics:

- Confirms lease signing date and location with client and landlord.
- Assists the client in turning on utilities/ transferring to client's name.

The Housing Locator reviews the terms of the lease with the client and both parties sign the lease. The Housing Locator maintains a copy of the signed lease in the client's file.

The Housing Locator confirms the transfer of keys and provides the household with a "Protect your Family from Lead in Your Home" brochure.

The Housing Stability Coach conducts an in-person meeting at the client's new home within 5 business days of the client moving in.

- The HSC completes a new SPDAT and Budget with the client.
- The HSC reviews the current Housing Stability Plan. o Updates action steps/ goals completed.
- Creates a new Housing Stability Plan now that housing has been obtained.

The Housing Stability Coach (HSC) updates information in CMS:

- Records security deposit/ utility deposit/ move-in costs in CMS.
- Creates a new Status Assessment and Housing Assessment to document the move-in date.
- Records the results of the SPDAT.

The Housing Locator assists the client in identifying and acquiring household goods and furniture needed at move-in.

- The Housing Locator and client assess the client's access to basic goods, and the Housing Locator assists the client in obtaining needed goods.

- The Housing Locator purchases household goods using the FAC Initiative Fund according to the FAC Initiative Fund policy, and requests reimbursements for these goods based on the Housing Resource Center Invoicing Policies.
- The Housing Locator records goods provided in the client's CMS profile under the Services section.

4. Support stabilization in housing

The Housing Stability Coach (HSC) provides ongoing, at least monthly, in-person case management to support the client in gaining stability in their housing.

- The focus of the case management meetings is to execute and review progress taken towards the action steps and goals outlined in the Housing Stability Plan, with the ultimate goal of helping clients maintain their own housing.
    - HSC records progress, completion of action steps, and other notes on the Housing Stability Plan during in-person meetings.
    - HSC creates a new Housing Stability Plan whenever new goals or action items are established.
    - HSC records all meetings and documents changes in CMS: • HSC creates a case note to record a summary of all case management meetings in the client's notes section. ⍰ These may be marked Private if they contain medical information, per the Case Note Sharing Policy.

• HSC records a Status Assessment update whenever a client's income, benefits, health documentation status, or health services change.
• HSC uploads all file documents, including updated Housing Stability Plans, budgets, SPDAT's, and other documents.

The HSC provides ongoing financial assistance to the client for housing and other needed costs, as appropriate for the household's needs.

- The HSC and client agree on housing costs to be paid by the HRC and by the client in 3-month increments and document in the Rental Agreement. o See Policy on Client Contributions to Housing Costs.
    - The HSC processes payment for housing costs according to the Housing Resource Center Invoicing Policies.
    - The client provides proof of payment for all housing costs to the HSC within 5 days of the rent due date.
- The HSC provides other financial assistance to the client for services/ items that help the client meet their goals and that they cannot pay for on their own. o The HSC and client will include on the Housing Stability Plan the client's and HRC's contribution towards these items, and the due date for the client to provide proof of payment.
    - The Housing Stability Coach will follow the FAC Initiative Fund policy to determine eligible items. • The FAC Program Manager will provide final approval on payment of items not listed on the FAC Initiative Fund policy.
    - The HSC processes payment for these items according to the Housing Resource Center Invoicing Policies.

5. Re-certify need for continuing assistance

The Housing Stability Coach will re-certify the client's eligibility and need for Rapid Re-Housing assistance every three months, which includes the following:

- Completion of the Re-Certification of Eligibility for Rapid Re-Housing Assistance form (Form 5.21) and related documents: o Completion of the Income Eligibility worksheet (Form 5.12) to determine that the client/household's income is at or below 30% of the Area Median Income.
    - Completion of the SPDAT and Monthly Budget to confirm continued need for Rapid Re-Housing services.
    - Update the current Housing Stability Plan to document progress on meeting goals at the time of re-certification.
    - Print case notes from the prior 3 months and attach to the Re-Certification packet.
    - The Re-Certification Form must be signed by the HRC Supervisor.
    - Creating a new Status Assessment in CMS.

• The Status Assessment is considered an Update for each re-certification for all except the re-certification occurring closest to the 1-year anniversary of the client's Program Entry date.
• The Status Assessment occurring closest to the 1-year anniversary of the client's Program Entry date is marked the "Annual Assessment".

If Re-Certification is approved:

- The HSC will complete the Rental Agreement for Re-Certification (Form 5.25) to confirm the amount of rental assistance to be provided for the next 3 months. o Housing Stability Coaches are expected to calculate the client's contribution towards rent after re-certification by following the policy on client contribution to housing costs and program guidance on re-certification.
    - The HSC processes payment(s) for housing costs and other costs as determined by the Rental Agreement and client need.
- The HSC will complete a new Housing Stability Plan.
    - The HSC continues to assist the client in their goals outlined in the Housing Stability Plan by connecting the household to mainstream & community services until the next 3-Month Assessment is due. Progress is monitored, at minimum, in monthly face-to-face meetings.

If Re-Certification is not approved:

- The HSC and client complete a Program Exit Plan (Form 5.18).
- The HSC provides the client with a Discharge Letter (Form 5.17) to confirm program discharge.
    - Provides a copy of the Grievance Procedures to client.
- The HSC completes the procedures to close the case.

For more information, see Program Guidance on Re-Certification of Rapid Re-Housing Clients.

6. Connect to Mainstream/Community Services

FAC is consistently looking to expand opportunities for Rapid Rehousing clients to be connected to community & mainstream resources that will help promote the housing, health, and economic stability of our clients. While connection to employment, SOAR, mental health, and Aging & Adult services are outlined below, FAC also encourages all core providers to refer to local community resources as well as specialized pilot projects within FAC , such as the Clarifi financial literacy counseling service or the ServSafe Certification program through Manna on Main Street. For the most up-to-date information on referral resources, contact the FAC Program Manager. Housing Stability Coaches use the results of the SPDAT assessment to evaluate the types of additional supports that a client will need to maintain housing stability.

Clients needing support for medical & health problems:

- HSC contacts the Samaritan Health supervisor, ????
- Client, if eligible, will be enrolled into the Medical Assistance Program (MAP) in CMS

Clients needing support related to obtaining employment:

- HSC completes the Employment Assessment in CMS for the client.
- HSC records the service "Referral to FAC Career Counselor" in CMS for the client.

Clients needing support to apply for Social Security Income/ Social Security Disability Income:

- HSC completes the SOAR Referral Forms (Forms 5.22 & 5.23)
- HSC emails the SOAR Referral Forms to the SOAR Specialist, ???? .
- HSC records the service "Referral to SOAR Specialist" in CMS, and marks the service as "private".

Clients needing support to connect to mental health services:

- HSC completes the Linn County Referral Form (Form ??.
- HSC sends Referral Form via email to the ????
- HSC records the service "Referral to CTI" in CMS, and marks as "private"

For any adult over the age of 18 who presents with concerns regarding abuse, neglect, exploitation, or abandonment, the following procedures will be followed:

- The HSC will call the LinnCounty Aging & Adult Services (MCAAS) protective hotline at 1-800-734-2020.
- Follow up inquiries regarding the result of the assessment can be directed to???

Note: protective service assessment reports cannot be released to outside agencies, including FAC .

  - If the assessment results in the need for Aging & Adult Protective Services, the Housing Counselor or Housing Stability Coach will continue to collaborate with the Protective Services Case Manager to coordinate care related to housing.
  - If the assessment does not result in the need for Aging & Adult Protective Services, but the client is 60 or older and in need of long term placement or in-home services, follow the procedure(s) below.

- The HSC will record 'Referral for Protective Services Assessment' service and note in CMS

Clients over the age of 60 who may need long term facility placement and are agreeable to placement:

- The Housing Stability Coach will obtain a signed release of information form from the client, granting permission to speak with and obtain information from ??.
- The HRC supervisor will check the SAMS database for client's name o If the client is active with MCAAS and has an assigned care manager/service coordinator listed, SHC/HSC will collaborate with the assigned ??? employee for housing related matters using the contact information listed in SAMS database.
  - If the client is not an active case with ??, a LOC assessment will be requested .

- The HSC will request an assessment to determine eligibility for nursing home placement by dialing ?? and specifically asking for a Level of Care assessment. This assessment can be completed within 15 days or sooner from the date it is requested. o Information needed to make a referral: Client's name, current address, phone number, emergency contact, Primary Care Physician's name, address, phone and fax numbers.
  - Note: A LOC assessment will determine if the client is eligible for placement only.
- Requests for the results of the LOC assessment or any follow up questions can be sent to the Intake Supervisor,
  - The HSC will add 'Referral for Level of Care Assessment' service and note in CMS

Clients over the age of 60 who wish to live in their own home with in-home supports/services:

- The Housing Stability Coach will obtain a signed release of information form from the client, granting permission to speak with and obtain information from ??.
- The Senior Housing Counselor and/or the HRC supervisor will check the??? database for client's name. o If the client is active with ??and has an assigned care manager/service coordinator listed, SHC/HSC will collaborate with the assigned ??mployee for housing related matters using the contact information listed in SAMS database.
    - If the client is not an active case with ??, a referral will be made to Maximus.
- To apply for in-home care, the HSC will call??????*with the client* by dialing ???????.
    - Information needed to make a referral: Client's name, current address, phone number, emergency contact, Primary Care Physician's name, address, phone and fax numbers.
    - ??? will then mail out a financial packet for the client to complete.
- Once the client receives the financial packet from, a referral will be made to financial advocacy unit to help the client with the completion of the paperwork. This can be done by calling intake at ?? and selecting the prompt for financial advocacy or calling supervisor ??? who will assign it to one of the financial advocates. o Note: Aging and Adult Services has several in-home service programs. These services are not immediate and seniors will have to wait for up to 60 days for services to be in place.
- The HRC will add 'Referral for In-Home Services' service and note in CMS

7. Refer or confirm referral to Permanent Supportive Housing as needed

As noted in the Coordinated Entry Program Guidance, some high acuity clients that are truly in need of Permanent Supportive Housing may be temporarily enrolled into Rapid Re-Housing until a Permanent Supportive Housing bed/ unit becomes available. In these cases, it is the HSC's responsibility to ensure that (1) the client is properly referred to the Permanent Supportive Housing Prioritization list, (2) all documentation is gathered and available so that the client can be enrolled into the program as soon as a bed becomes available for them, and (3) the Permanent Supportive Housing Prioritization Committee is kept updated on the client's status in the Rapid Re-Housing program (such as program discharge, time remaining on temporary subsidies, etc).

- The HSC and their Supervisor will evaluate all high acuity clients for PSH need. A need for Permanent Supportive Housing would be indicated by a combination of all factors below:
    - Consistently high acuity or lack of progress on decreasing acuity over time.
    - Presence of a severe, life-long disability that significantly impairs the client's ability to care for him/herself without intensive, ongoing supports, and documentation of such.
    - A history of literal homelessness of at least 12 months, consecutively or cumulatively over the last 3 years.
- The HSC gathers the required documentation for Permanent Supportive Housing, including all assessment documentation.
- The HSC refers eligible clients to the Permanent Housing Advisory Team by emailing the name of the client to the Committee Chair

8. Close the case

The HSC exits the client from the program when:

- The client is no longer eligible for or in need of Rapid Re-Housing services, as indicated by the Re-Certification assessment, completion of goals as outlined in the Housing Stability Plan, and documented financial ability to meet basic living needs (see Program Guidance).
- The client has been discharged according to the Rapid Re-Housing Client Exit/Termination Policy

The HSC completes the exit paperwork:

- Completes the Program Exit Plan (Form 5.18) with the client.
- Sends the client and landlord a program exit letter (Forms 5.17 & 5.28). o Provides a copy of the Grievance Procedures to client.
- Updates notes and client file paperwork to document the reason for discharge.
- Exits the client from the Rapid Re-Housing program in CMS.

Output and Outcome Measures

The following measures will be used to evaluate the performance of the Family Assistance and Resource Group Rapid Re-Housing program:

- Number of persons/ Households served (by household composition)
- Number/ Percentage of persons/ households re-housed
- Average length of time from HRC intake to move-in date
- Average length of stay in program
- Number/ Percentage of persons exiting to permanent housing
- Number/ Percentage of adults exiting with any income
- Number/ Percentage of adults exiting with earned income
- Number/ Percentage of adults exiting with non-cash benefits
- Number/ Percentage of persons exited to permanent housing who return to emergency shelter within 2 years of exit

Program Guidance

Re-Certification for Rapid Re-Housing Clients

Housing Stability Coaches (HSC) are required to conduct a 3-month re-certification of all Rapid Re-Housing clients to determine if a client is eligible to receive additional rental assistance and case management support from the program.

When assessing a household's eligibility for re-certification, HSCs and their Supervisors should use the following framework outlined below. It is the responsibility of the Housing Stability Coaches and their Supervisors to continuously assess the following areas during the 3 month interval in which they have last been approved. Abiding by the Rapid Re-Housing Client Exit/Termination Policy, a client should be either approved for another 3 months of assistance or exited off the program at the close of the 3 months.

- **Assess income eligibility-** All households' income must be at or below 30% of the Area Median Income in order to continue to qualify for assistance through the program. If a household's income exceeds this limit at the time of re-certification, the household may not be approved for re-certification. *If a household is still in need case management services for referrals to community supports in order to meet goals outlined in the Housing Stability Plan, the household may be re-certified without financial assistance (case management services only).*
- **Assess financial resource eligibility-** All households must be in need of financial assistance in order to continue to qualify for assistance. This is most accurately assessed by reviewing the household's monthly budget, assets, and other resources available to them to support housing costs. If a household is still under 30% AMI but is able to maintain housing costs on their own through their own resources, then the household may not be approved for re-certification. The household's ability to support basic needs within their own financial resources must be clearly documented through the Program Exit Plan (Form 5.18) and Household Budget (Form 5.16). These case management forms must outline clearly the resources available to the client (such as food banks, enrollment in LIHEAP or other utility assistance programs, etc.) and how, through the utilization of these resources, they are able to maintain housing costs. *If a household is still in need case management services for referrals to community supports in order to meet*

goals outlined in the Housing Stability Plan, the household may be re-certified without financial assistance (case management services only).

- **Assess for supports eligibility-** All households must be in need of the case management supports provided by the program in order to qualify for re-certification. This is most accurately assessed by reviewing the household's SPDAT history, Housing Stability Plan progress, and case notes. Households must have a demonstrated need for continued case management support as shown through these documents. Households that do not have a need for case management support may not be re-certified. *Note that Coaches are only assessing for case management need during re-certification, not compliance with case management services.* • SPDAT: The SPDAT provides information as to whether a client is able to manage barriers to housing stability. A reduction in SPDAT score across multiple categories would indicate that a client has been able to access and utilize those supports needed to manage these barriers. Consistently high acuity, or increasing acuity over multiple categories, would be an indication that case management supports are still needed. This is especially true if a client has identified barriers, but is unable to access or use resources/ supports effectively to mitigate those barriers to stability.

- Alternatively, if a client has decreased in acuity as a result of improved management of issues, or connection to community supports to help manage issues, then this would indicate a decreased need for case management supports.
- HSCs should never use a decrease in one area of the SPDAT as the sole reason for discharge or re-certification- HSCs should use the whole SPDAT to understand the client's "big picture" needs and barriers, and to assess overall need for case management supports as result.

• Housing Stability Plan: The Housing Stability Plan provides information about whether a client has met the goals that will enable them to maintain their housing without case management support. A client who has met their Housing Stability Plan goals would likely not need continued case management supports to maintain their housing.

- A client who has achieved most or all of the goals on the Housing Stability Plan would likely not need continued assistance from the program.
- A client who has not been able to achieve their goals, or has only achieved their goals very recently, would likely need more case management support to continue to try to achieve the goals in the Housing Stability Plan.
- HSCs should only be assessing clients for goal *achievement* during re-certification, not for compliance with trying to achieve goals. If a client has not followed through with actions identified in their Housing Stability Plan, this should be addressed using the policies on the Rapid Re-Housing Program Agreement (Form 5.29) and Client Exit/ Termination policies.

• Case notes: Case notes will provide additional information to support the determination made by the HSC regarding achievement of Housing Stability Plan goals and ability to manage barriers to housing stability. The SPDAT and Housing Stability Plan do not provide enough justification and case history on their own to clearly demonstrate the client's eligibility for services. Detailed, timely, and accurate case notes must be included in order to properly document the eligibility determination. Case notes must provide a consistent case history that matches and supports the results of the SPDAT and the work completed on the Housing Stability Plan.

- Case notes should be reviewed by Supervisors periodically to ensure that enough information is recorded to support case management decisions made by the Coach.
- Coaches must follow the policies, procedures, and training provided on completing case notes.

Even with these tools, re-certification for support may be difficult to determine, and HSCs and Supervisors will need to communicate regularly about this process in order to develop consistency in practice. Supervisors are responsible for ensuring that the re-certification process is being completed fairly and consistently for all clients,

and that HSCs are completing the re-certification process without bias (such as that against “difficult” or “hard to engage” clients). Supervisors are also responsible for ensuring that HSCs are documenting their work sufficiently. Housing Stability Coaches and Supervisors should engage in training and learning opportunities offered by Family Assistance and Resource Group to continue to increase assessment skills and provide consistent assessments for clients.
Overall, it is important for Housing Stability Coaches, clients, and Supervisors to be engaging in discussions about the client moving to self-sufficiency from intake and throughout the client’s time in the program.

Progressive Engagement in Rapid Re-Housing

Family Assistance and Resource Group’s Rapid Re-Housing program is based on the model of progressive engagement, which means that households are provided the least amount of resources needed to achieve housing stability. In practice, this is carried out in a few ways: (1) Financial assistance is provided in no more than 3 month increments, and households are assessed for continued financial need before receiving more assistance; (2) There are no standard program service requirements other than basic case management (such as savings programs, educational achievement, life skills classes, etc).
Progressive engagement requires that Housing Stability Coaches (HSC) and their Supervisors are constantly assessing client needs and abilities and tailoring their services accordingly. In terms of case management services, the level of service and support can be adjusted in the following ways to better match client needs:
(1) Increasing frequency of case management meetings. While the basic program requirement is that HSCs meet with clients once per month, HSCs may determine that a client needs more frequent meetings in order to accomplish goals. a. Possible indications of need to increase case management frequency: i. Client acuity demonstrates high barriers to obtaining housing, particularly in areas such as Tenancy, Mental Health and Wellness, History of Homelessness.
ii. Client is unable to stay organized or on track between case management meetings; frequently loses paperwork, is unable to remember or accomplish action steps on own.
iii. Client has cognitive, developmental, or behavioral issues that have or may prevent them from accomplishing tasks or daily living activities.
iv. Client has drug or alcohol use behaviors that may limit memory or ability to complete tasks on time.

b. Housing Stability Coach response: i. Increase the number of in-person and/or phone meetings to more than once per month, such as biweekly or weekly.
ii. Engage additional supportive services, such as CTI or Recovery Coaches, to help the client achieve goals. Hold joint meetings so that all supports are aware of action steps and goals and ensure that these supports are assisting in completion of goals.
iii. Provide text message reminders or other prompts to complete tasks such as payment of rent or other bills.

(2) Increasing supportive services. Some clients may need additional support in achieving housing goals or support in achieving other goals from other community support resources. a. Possible indications of need to increase supportive services include: i. Client acuity demonstrates high barriers in certain areas needing professional services, support, or care, such as Mental and Physical Health and Wellness, Trauma/ Abuse, Family, etc.
ii. Client’s lack of history or ability with certain skills, such as employment, tenancy, financial literacy.
iii. Client’s high score in Managing Tenancy or lack of tenancy history; high barriers identified to obtaining housing such as evictions, criminal history, etc.

b. Housing Stability Coach response: i. Make referral to non-housing supportive services, and follow up with referral to ensure that client is able to access these services. Hold joint meetings to ensure that all supportive services are in place, all providers understand service goals, and support is being provided to help client achieve goals.

ii. Increase the level of support provided to clients to achieve housing goals, such as sitting with a client to call potential landlords, teaching a client how to make a rent or bill payment, teaching a client how to keep an apartment clean, helping a client complete a benefits application, connecting client to a Representative Payee, etc.

(3) Adjusting Housing Stability Plans. Some clients may need to break goals down into smaller action steps in order for these plans to be manageable. a. Possible indications of need to adjust Housing Stability Plans: i. Client is unable to complete tasks as assigned or is unable to make progress on goals.
ii. Client has not completed similar tasks before and is unsure of how to start.
iii. Client has developmental, behavioral issues and/or significant substance use habits that make goal achievement challenging.

b. Housing Stability Coach response: i. Engage other support service professionals in creating an appropriate Housing Stability Plan for client based on abilities.
ii. Break tasks down into smaller actions, and assign case management support for each action.
iii. Check in more regularly on progress towards achieving goals.

Housing Stability Coaches and their Supervisors are responsible for ensuring that an appropriate level of supportive services is provided to all clients. Clients with high needs should not be provided the same level of case management as those with lower needs- this is against the Progressive Engagement model. Rather, they should be provided the level and type of service and supports necessary to achieve housing stability, as soon as that level of need is identified. For example, if a higher level of support is identified from intake, then that level of support should be provided immediately.
If needs exceed the capacity or training of Housing Resource Center staff, then HRC staff must ensure that clients are referred and connected to appropriate supports.

Rapid Re-Housing Case Loads

Housing Resource Center Supervisors are expected to help Housing Stability Coaches maintain a “mixed” level of Rapid Re-Housing cases; meaning, each HSC should be working with a set of clients with a mix of acuity levels and time in program.
On average, HSCs should be carrying a case load of 30-35 clients. In general, this should correspond to the following distribution:
- A mix of about 20% high need/ high acuity clients, 70% medium need/ medium acuity clients, 10% low acuity/ low need clients

Note that “high needs” may be indicated by SPDAT score, health status/ needs, daily living needs, or be situational for clients experiencing issues that require a significant amount of case time (such as the move-in period, in a hotel, etc.).

Policies

Family Assistance and Resource Group Service Provider staff are encouraged to become familiar with all FAC Policies.
The Family Assistance and Resource Group Policy sections listed below provide guidance and direction for the implementation of FAC Rapid Re-Housing services.

2. Prioritization Policies
6. Case Management Tools And Assessment Policies
7. Rapid Re-Housing Policies

8. Landlord Retention and Engagement Policies

Transitional Housing

Many communities still operate congregate transitional housing programs – defined as facility-based programs that offer housing and services for up to two years to individuals and families experiencing homelessness. While many people who have traditionally been assisted in long-term congregate transitional housing may be served more efficiently in other program models, this model may be appropriate for some people, including persons struggling with a substance use disorder or in the early stages of recovery who may desire more intensive support; survivors of domestic violence and other forms of severe trauma who may require and prefer the security and onsite services of a congregate setting; unaccompanied and pregnant or parent youth who are unable to live independently or who prefer a congregate setting with access to a broad array of wraparound services.

Guiding Principles of Transitional Housing

[2] National Alliance to End Homelessness. The Role of Long-Term, Congregate Transitional Housing in Ending Homelessness, March 2015. http://www.endhomelessness.org/library/entry/the-role-of-long-term-congregate-transitional-housing-in-ending-homelessns

- **Reduce stays in congregate transitional housing-** Long-term stays in congregate transitional housing programs should be reserved for those individuals with severe or specific needs who choose transitional housing over other services that would help them more quickly reconnect to permanent housing.
- **Eliminate barriers-** Programs serving these populations should have as few barriers as possible to program entry (e.g. sobriety requirements) and to continuation in the program.
- **Exit to permanent housing-** Transitional housing services should focus on connecting individuals and families to permanent housing by program exit.
- **Coordination-** Entry into Transitional Housing should be coordinated with the community's broader coordinated entry system, including prioritization of services for those most in need of this.

Target Population

Literally Homeless (HUD Homeless Category 1)	Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: 1. Has a primary nighttime residence that is a public or private place not meant for human habitation; 2. Is living in a 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 and local government programs); or 3. Is exiting an institution where (s)he has 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	

Major Steps

1. Receive referral, complete intake and enrollment

The Transitional Housing Intake Worker contacts the FAC Program Manager for referrals when a unit is available.

The FAC Program Manager coordinates with Housing Resource Center Supervisors and Shelter Supervisors to identify potential candidates for Transitional Housing.

The candidate's information is sent to the Transitional Housing Intake Worker.

The Intake Worker completes the program's intake and selection process consistent with internal program policies and procedures.

- Applicants must meet program eligibility requirements.
- Applicants will be prioritized for entry into the program according to the program's prioritization system.

The Transitional Housing Case Worker follows the program's enrollment procedures.

- Complete program intake paperwork.
- Create all client profiles in CMS and enroll household into transitional housing program.

2. Provide a safe place to sleep

The Transitional Housing Case Worker provides a unit for the household to live in during their time in the program, consistent with agency's internal policies and procedures.

3. Provide case management to increase income and improve self-sufficiency

The Transitional Housing Case Worker provides case management services to connect households to income, mainstream benefits, community resources, and other supports necessary to improve the self-sufficiency of the household during their time in the program.

The Transitional Housing Case Worker updates CMS records to denote all changes in income and benefits.

The Transitional Housing Case Worker completes the Annual Assessment in CMS at least once per year.

4. Exit to permanent housing

The Transitional Housing Case Worker provides case management services to connect the household to permanent housing by the end of the program (up to 24 months).

Households that cannot be exited to permanent housing are referred to other community resources, including FAC 's Call Center, as appropriate and according to program's internal policies and procedures.

5. Close the case

Upon exit from the program, the Transitional Housing Case Worker closes out all agency paperwork according to program procedures.

The Case Worker exits the household from program in CMS.

The Intake Worker will inform FAC Program Manager of available unit.

Output and Outcome Measures The following measures will be used to evaluate the performance of the FAC Transitional Housing program.

- Percentage of adults connected to non-cash benefits at exit
- Percentage of adults receiving any income at exit
- Percentage of adults receiving earned income at exit
- Percentage of all clients exiting to permanent housing

Program Guidance

Program guidance for Transitional Housing providers will be added to the Operations Manual in future updates.

Policies

Family Assistance and Resource Group Service Provider Staff are encouraged to become familiar with all FAC Policies.

The Family Assistance and Resource Group Policy section listed below provides guidance and direction for the implementation of FAC Transitional Housing services.

2. Prioritization Policies

Family Assistance and Resource Group Policies

1. Client Assessment and Screening Policies

1.1 Screening and Assessment at the Family Assistance and Resource Group Call Center

The Family Assistance and Resource Group Call Center serves as the initial Screening and Assessment point for all Family Assistance and Resource Group services. All callers receive an initial Screening, which determines basic eligibility for any Family Assistance and Resource Group service.

Callers who do not pass the initial Screening are referred to other community resources based on the information provided to the Call Center Navigator in the Screening interview, and according to the Policy on Screening for Basic Eligibility for Family Assistance and Resource Group Services.

Callers that pass the initial Screening will receive an Assessment, using the appropriate Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT) – either the version for families with children, the version for unaccompanied single youth under the age of 24, or the version for single adults. Both the Screening and the Assessment questions are contained within the same form, the Family Assistance and Resource Group Referral Assessment in CMS. Callers are referred to the appropriate Family Assistance and Resource Group referral point once the Assessment is completed.

1.2 Households Reaching Family Assistance and Resource Group Call Center After Hours

Family Assistance and Resource Group Call Center navigator s will be available to conduct the full screening and assessment for Family Assistance and Resource Group between the hours of 8:00 am and 7:00 pm Monday – Thursday and 8:00 am and 6:00 pm on Fridays. After these hours and on weekends, anyone reaching out to Family Assistance and Resource Group will receive a live voice from a 2-1-1 resource navigator. Callers will then complete the pre-screen questionnaire with the resource navigator. If the caller passes basic eligibility for Family Assistance and Resource Group services, 2-1-1 staff will request that the household calls back during regular business hours to conduct a full Family Assistance and Resource Group Referral Assessment. Additionally, the 2-

1-1 resource navigator will provide referrals to local community resources as appropriate and as outlined in the LinnCounty Fast-Track Resource Guide, which may include:

- Food banks
- Day Shelters
- Non-participating Family Assistance and Resource Group Shelters
- Homeless Prevention Resources
- Emergency and Crisis Resources
- Code Blue Resources (during declared Code Blue nights)

If a household informs the 2-1-1 resource navigator that children under the age of 18 are sleeping in a place not meant for human habitation, the resource navigator will ensure a direct referral and connection to the 24/7 Family Assistance and Resource Group Street Outreach team.

1.3 Screening for Basic Eligibility for Family Assistance and Resource Group Services

The Family Assistance and Resource Group Call Center will complete an initial Screening (Pre-Screen) on all callers for basic eligibility for Family Assistance and Resource Group services. Basic eligibility includes:

1. Domestic violence status: Family Assistance and Resource Group services are available to persons fleeing domestic violence if services from a Domestic Violence Victims Provider Agency are not available or the caller does not qualify for services from a Domestic Violence Victims Provider Agency.

The Call Center Navigator will refer any person actively fleeing domestic violence to the Laurel House Domestic Violence Hotline first, before screening or assessing for Family Assistance and Resource Group services. If services are unavailable to the client through the Domestic Violence system, the caller will be Screened and Assessed for Family Assistance and Resource Group services. The caller has a right to refuse to call the Laurel House Domestic Violence Hotline. In these instances, the Call Center Navigator will screen & assess for services through Family Assistance and Resource Group.

2. County residency: In general, Family Assistance and Resource Group services are only available to persons who can provide documentation of residency in LinnCounty for at least 60 days.

- An exception is made for persons who are confirmed as street homeless by the Street Outreach navigator , in which case emergency shelter services (shelter or hotel stay for persons with medical need) may be provided for up to 3 days. No further services through Family Assistance and Resource Group will be provided for non-residents.
- Any caller who is not reporting street homelessness will be screened for residency according to the policy on County Residency. These callers must be able to meet the requirements of this policy in order to meet basic eligibility for Family Assistance and Resource Group services.
- Any caller who is reporting street homelessness will be asked about their residency status. Callers who cannot meet the residency requirement will be referred to services in their County of origin and will be informed of Family Assistance and Resource Group's residency policy and the limitations on services available for non-county residents. At that time, Out of County callers who are category 1 homeless may choose to continue with Screening and Assessment, in which case the Call Center will complete the Screening, Assessment, and referral to street outreach as appropriate for a person reporting street homelessness.

3. Current housing status: Family Assistance and Resource Group services are only available to persons who are literally homeless, doubled-up, in a hotel paid for with their own funds, or a veteran at-risk of homelessness as demonstrated by meeting one of the following criteria:

- Literally Homeless: An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

• Has a primary nighttime residence that is a public or private place not meant for human habitation;

• Is living in a 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 and local government programs); or
• Is exiting an institution where (s)he has 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

- Doubled-Up/ Couch-Surfing: An individual or household temporarily living in the home(s) of others due to economic hardship and who must leave this housing situation immediately.
- Living in a Hotel or Motel: An individual or household living in a hotel or motel and the cost is not paid for by a charitable organization or by Federal, State, or local government programs for low-income individuals.
- Fleeing/ Attempting to Flee Domestic Violence: Any individual or family who is fleeing, or is attempting to flee, domestic violence and has no other residence; and lacks the resources or support networks to obtain other permanent housing.
- Veteran at-risk of Homelessness: a veteran, as defined as "a person who served or is serving in the active military or air service" who is imminently at-risk of literal homelessness but for SSVF assistance.

Callers who do not meet the basic eligibility for Family Assistance and Resource Group services as described above are referred to other community resources. Other community resources are identified through use of the 211 database. Community resources may include:
• The Cardva Hotline
• Any emergency shelter in LinnCounty that does not participate in the Family Assistance and Resource Group coordinated entry system
• The Coordinated Entry system and/or emergency shelters in a non-LinnCounty residents' county of origin
• Community-based organizations that have provided their information to the 211 database for service referrals
• Legal Aid of Linn County

Client-level data on callers that do not meet the basic eligibility identified in the Screening is not entered into CMS, but is maintained within the Family Assistance and Resource Group Call Center's internal database (Resource House) for quality assurance purposes.
Callers who meet the basic eligibility will be asked to complete the Assessment for Family Assistance and Resource Group services. Client-level data on callers that meet the basic eligibility is entered into CMS.

1.4 Callers Refusing Assessment

Callers passing basic screening and reporting literal homelessness, but who otherwise refuse to complete the VI-SPDAT or engage further with the Call Center Specialist, will be referred directly to the Street Outreach team via CMS. The Call Center navigator will complete the CMS profile to the best of their ability, based on the information given by the caller. The navigator will then refer directly to Street Outreach via CMS, passing along the information that the client was willing to share in regards to how they can be contacted or where they can be found.
Street Outreach, upon engaging the client and receiving permission, will then complete the full Family Assistance and Resource Group Referral Assessment. Services will be available to the client based on Family Assistance and Resource Group prioritization policies.
If Street Outreach continues to engage, but the client continues to refuse engagement or assessment, Street Outreach will notify the Family Assistance and Resource Group Program Manager.

1.5 Callers Fleeing Domestic Violence

The Family Assistance and Resource Group Call Center will ask all callers during the initial Screening for basic eligibility if they are actively fleeing a domestic violence situation. If a caller reports that they are fleeing domestic violence, the Call Center will offer the caller the Laurel House Domestic Violence Hotline for assessment.

The Laurel House Domestic Violence Hotline staff assesses all callers using an internal assessment. Callers who meet the Laurel House Domestic Violence Hotline assessment criteria will be connected to Laurel House's emergency shelter, or, if no space is available, with the phone numbers for other domestic violence shelters in the region and the Family Assistance and Resource Group Call Center number. Callers that do not meet the Laurel House Domestic Violence Hotline assessment criteria will be referred to the Family Assistance and Resource Group Call Center among other referrals as determined appropriate by the Laurel House Domestic Violence Hotline staff.

Callers that have already called the Laurel House Domestic Violence Hotline and had been referred back to the Family Assistance and Resource Group Call Center will be screened and assessed for Family Assistance and Resource Group services and may be referred to Family Assistance and Resource Group emergency shelter or other services as appropriate.

Callers fleeing domestic violence must be able to provide documentation of current LinnCounty residency in order to receive services through Family Assistance and Resource Group; however, the requirement for 60 days' worth of residency may be waived in order to accommodate the safety needs of this population.

1.6 Clients Reporting Military History

On October 17, 2017, the U.S. Department of Veterans Affairs (VA) Deputy Under Secretary for Health for Operations and Management released a memo to the VA Network Directors, VA Network Homeless Coordinators, and VA Medical Center (VAMC) staff which issued guidance regarding the roles and responsibilities of the VA medical center homeless programs in each of the local Continuum of Care (CoC) and the CoC's Coordinated Entry Systems (CES). This guidance from the VA to the VA medical centers is meant to support community planning and CES efforts within CoCs by clearly outlining the expectations of VA medical center involvement and Supportive Services for Veteran Families (SSVF) involvement.

Within the guidance, VA recognizes that coordinated entry systems are a critical element in our collective and continued efforts to end Veteran homelessness and homelessness for all populations. Coordinated Entry ensures coordination of community-wide services for Veterans experiencing homelessness, system-wide awareness of the availability of housing and services, and easy access to and appropriate prioritization for these resources by Veterans who are in critical need.[3]

[3] 5 U.S. Department of Housing and Urban Development From Our Federal Partners: VA and Coordinated Entry Systems (CES) Memo, November 2017.
https://newsletterlog.com/from-our-federal-partners-va-and-coordinated-entry-systems-ces-memo/

To fulfill this guidance, the Family Assistance and Resource Group Call Center will ask all callers during the initial Screening for basic eligibility if they have ever served in the U.S. military or air service. If a caller reports that they have active or past military history and are experiencing Category 1 literal homelessness, the Call Center will refer the caller directly (via CMS) to the SSVF Outreach Program. If a caller reports that they have active or past military history and are in a housing crisis, the Call Center will refer the caller directly (via CMS) to the SSVF Homeless Prevention Program after completing the remainder of the Screening and Assessment.

SSVF Outreach Worker will follow all of the major steps and policies outlined for homeless street outreach services within Family Assistance and Resource Group. The SSVF Outreach Worker will refer any confirmed literally homeless veteran households to SSVF Rapid Re-Housing Program directly via CMS upon the first in-person homeless verification meeting. The SSVF Outreach Worker is also responsible for referring directly for a HUD VASH assessment as appropriate after the first in-person homeless verification meeting.

Veterans that are eligible for Veteran's housing services will not be served through the Family Assistance and Resource Group Rapid Re-Housing Program.

If a Veteran is deemed ineligible for SSVF programs (RRH or Homeless Prevention) and/or HUD VASH, the veteran household must be notified in writing of the reason for denial of services and offered a grievance procedure.

Veterans experiencing Category 1 homelessness that are ineligible for Veteran's housing services will be served

through Family Assistance and Resource Group Rapid Re-Housing program. In these instances, a direct referral to the Community Queue will be made by the SSVF provider the same business day that the denial has been issued.

1.7 Callers Being Discharged from a Public Institution

This policy applies to callers being discharged from Public Institutions including Jail, Hospital, Foster Care, or Substance Use Facility/Detox. Appropriate discharge planning from public institutions is paramount to reducing homelessness among vulnerable populations, including chronically homeless persons, youth aging out of foster care, persons with forensic history, and persons with chronic substance use issues. Discharging these vulnerable populations directly to shelters or the streets put them at increased risk for infection and poor recovery, recidivism into the prison system, and relapse, among other risks. Emergency shelters are not equipped to provide the care needed for these populations to recuperate safely following a stay in a public institution, and in many cases their presence in congregate living facilities may even put others at risk.

Family Assistance and Resource Group expects that public institutions will not discharge vulnerable residents directly to homelessness, including directly to the Family Assistance and Resource Group Call Center or emergency shelter. Family Assistance and Resource Group will not accept inappropriate discharges from public institutions in order to protect these residents from recuperating in settings that are harmful to their health and welfare, and to protect the health and welfare of other residents and Family Assistance and Resource Group staff.

The Family Assistance and Resource Group Call Center will screen all callers being discharged from a public institution to determine if the caller meets the criteria of Literally Homeless as defined by HUD, prior to proceeding with the Screening and Assessment. Note that HUD defines literal homelessness, as it relates to institutions, as being a person who has been in an institution for less than 90 days and was residing in a place not meant for human habitation prior to entering the institution. Any caller not meeting these criteria will not receive a full assessment and will not be referred to any Family Assistance and Resource Group services, including Emergency Shelter. If a representative from the institution feels that a caller who is not meeting federal criteria needs special consideration, that representative will contact the Family Assistance and Resource Group Program Manager directly to complete a case consultation.

If a caller does meet the federal criteria for homelessness in an institution, the caller will be assessed and a referral sent directly to Street Outreach. Street Outreach will contact the client and the client's social worker at the institution to verify literal homeless status prior to entry into the institution. The caller will be eligible for Family Assistance and Resource Group services at that time, including for Emergency Shelter. The caller will be prioritized for Family Assistance and Resource Group programs and services based on Family Assistance and Resource Group's prioritization policies. **Family Assistance and Resource Group Emergency Shelters are prohibited from accepting clients directly from public institutions over higher acuity clients still on the waitlist**.

If a social worker has an inquiry about the caller's VI-SPDAT score and/or their spot on the community queue to get into emergency shelter, that social worker will contact the Family Assistance and Resource Group Program Manager.

1.8 County Residency

To qualify for any Family Assistance and Resource Group services, a client must be a County resident for at least 60 days and have documentation of residency for 60 days. Acceptable forms of documentation to determine County-level residency for the purpose of receiving services from Family Assistance and Resource Group include the following:

1. Federal, State or Local jurisdiction issued form of identification such as (Driver's License, Non-Driver ID, Passport, Military ID etc.)
2. Original utility bill in the individual's name indicating a County residential address

3. Signed/verifiable lease in the individual's name from a County residential address
4. Documents proving the receipt of public benefits in that County
5. People without a formal ID or any other documented residency will be considered residents of a County if certified by a County-authorized community service provider (e.g., recent immigrants, people living in places not intended for human habitation, etc.)

The Call Center will screen all callers for residency. Out of County callers will be referred to services in their County of Origin (defined as the county corresponding to their last documented permanent residence) and will be informed of Family Assistance and Resource Group's residency policy and the limitations on services available for non-county residents. At that time, Out of County callers who are street homeless may choose to continue with Screening and Assessment, in which case the Call Center will complete the Screening, Assessment, and referral as appropriate for a person reporting street homelessness. *Note that this exception applies only to persons who are confirmed as street homeless- callers who have been living in hotels or living doubled-up in LinnCounty must be able to document residency through one of the means above for the prior 60 days in order to be eligible for any Family Assistance and Resource Group services.*
Non-county residents who are confirmed as street homeless by the Street Outreach navigator may receive up to 3 days of emergency shelter services (shelter or hotel stay for persons with medical need) as space is available and according to prioritization policies. No further services through Family Assistance and Resource Group will be provided for non-residents.
Note that County residency does not apply to persons seeking to enroll in the Domestic Violence shelter in LinnCounty through the Domestic Violence hotline. However, residency in the County must be established through one of the means listed above in order for clients currently enrolled in the Domestic Violence shelter to be eligible for Family Assistance and Resource Group Rapid Re-Housing, Transitional Housing, or Permanent Supportive Housing. The 60-day requirement does not apply to these cases.

1.9 Selection and Use of the VI-SPDAT During Call Center Assessment

The Family Assistance and Resource Group Call Center will complete an Assessment of all callers that pass the initial Screening for basic eligibility for Family Assistance and Resource Group services. The Assessment is the Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT). In CMS, both the Screening questions and the Assessment questions are contained in a single form, called the Family Assistance and Resource Group Referral Assessment. This form is saved within the client's record in CMS and used for all referral-making and prioritization.
The Family Assistance and Resource Group Call Center Navigator will select the appropriate version of the Family Assistance and Resource Group Referral Assessment to complete in CMS based on the household composition of the caller. Households with children under the age of 18 will complete the Family Assistance and Resource Group Referral Assessment for Families (which contains the F-VI-SPDAT, the version for Families). Unaccompanied youth under the age of 24 without their own children will complete the Family Assistance and Resource Group Referral Assessment for Youth (which contains the TAY VI-SPDAT, the version for youth). Single adults over the age of 24 will complete the Family Assistance and Resource Group Referral Assessment for Single Adults (which contains the VI-SPDAT for single adults). Households that contain multiple adults will be asked to complete a separate Family Assistance and Resource Group Referral Assessment for Single Adults for each adult in the household. If the adults intend to present together for services, only the highest scoring assessment will be used for referral purposes.

1.10 Third Party Assistance During Call Center Screening and Assessment

At times, it may be necessary or advisable for a third party to assist a person in calling the Family Assistance and Resource Group Call Center. Such situations may include but are not limited to: a physical disability or significant health condition which prevents the client from speaking on the phone; a significant mental health condition that

prevents the client from understanding/ interpreting questions and responding appropriately; presence in an institution which regulates access to phones, such as a jail. Family Assistance and Resource Group encourages knowledgeable third
parties to assist persons in making the call to the Call Center, so that no person is denied access to services as a result of an inability to call on their own.
In any situation in which a third party is assisting a caller in calling the Family Assistance and Resource Group Call Center, the third party is expected to:
• Identify themselves to the Call Center Navigator with their name, title, and company/ organization;
• Provide their contact information for follow-up by the Call Center or a Family Assistance and Resource Group service provider;
• Accurately repeat or clarify questions asked to the caller, when a client needs assistance in understanding or interpreting the question;
• Allow the client to answer questions themselves, to the best of their ability;
• Give additional information to the Call Center Navigator if their experience with the client would provide more accurate responses;
• Assist the caller in understanding the Family Assistance and Resource Group process for referrals and help facilitate follow-up conversations or actions as necessary.

1.11 Screening, Assessment, and Referral Information Provided to Callers

All persons have a right to know the results of their screening and assessment, and as much information as possible about the services available to them and the timeframe for receiving those services.
During the Call Center Screening and Assessment, all callers will be provided the following information by the Call Center Specialist:
• The result of the Screening, including reason for meeting or not meeting the basic eligibility for Family Assistance and Resource Group services.
• The result of the Assessment, including the final score of the VI-SPDAT and the service to which the client is being referred (Street Outreach/ Emergency Shelter or Housing Counseling).
• How Family Assistance and Resource Group prioritizes for different programs
• To the extent feasible, an approximate timeframe within which the caller will receive a call back from a partner organization.
• Community Queue Check-In and update policies.

The Call Center Navigator does not provide approval for any type or duration of assistance from any Family Assistance and Resource Group provider, does not refer directly to Rapid Re-Housing/ Transitional Housing/ Permanent Supportive Housing, and does not provide specific dates on which a service will be provided by a Family Assistance and Resource Group provider. The Call Center does not provide any direct services to callers. Any questions from callers or advocates regarding an anticipated date of intake must be directed to the Family Assistance and Resource Group Program Manager.

1.12 Community Queue Check-In

All persons waiting for emergency shelter or housing counseling must call the Call Center to check in at least once every 30 days if they have not received a call from a Family Assistance and Resource Group provider in that timeframe. The Call Center records all caller check-ins in CMS.
All persons in emergency shelter and waiting for Rapid Re-Housing services must connect with their shelter case worker to check in on the Community Queue at least once every 30 days in order to remain active on the Community Queue. The Shelter Case Worker will record the client's check-in.
The Community Queue will automatically purge any referral records for all clients that have not checked in during the past 30 days.

1.13 Changes to housing status during client check-in

After a caller completes the Screening and Assessment, and while waiting for a service connection, their housing situation or other information may change. All callers are encouraged to call the Call Center if their housing situation changes during the first thirty days in which they are waiting for service connection.

In the event a caller contacts the Call Center to update their housing status information within 30 days of the original call, the Call Center will update the original Family Assistance and Resource Group Referral Assessment completed for the client.

1.14 Re-Assessment after 30 Days

Any caller not in emergency shelter who has not been enrolled into any services within 30 days of their initial call to the Call Center will be asked to complete a new Assessment.

The Call Center Navigator will complete a new Family Assistance and Resource Group Referral Assessment in CMS, and create a new referral for the caller based on this assessment. The Call Center Navigator will contact the Family Assistance and Resource Group Program Manager to delete the original referral connected to the original assessment.

1.15 Grievances with Call Center Screening Determination

All callers and client advocates have a right to appeal the basic eligibility determination made by the Call Center Navigator during the caller's Screening.

Callers who feel that they have been denied services to which they were eligible may voice their grievance by contacting the Family Assistance and Resource Group Program Manager directly, send an email or notice via Family Assistance and Resource Group's website or social media accounts, or through other means available to them. The Family Assistance and Resource Group Program Manager will assess all grievances with the Call Center Specialist's Screening of the client by: (1) Reviewing the CMS notes and/or Call Center internal database notes (including summary transcript or recording of recorded call); (2) Speaking with the client directly to further understand their current situation; and (3) Interviewing the Call Center Navigator who completed the Screening. Caller advocates filing a grievance on behalf of a caller will submit their grievance directly to the Family Assistance and Resource Group Program Manager via email.

The Family Assistance and Resource Group Program Manager will make a final determination on the client's basic eligibility based on the information available compared against the Family Assistance and Resource Group basic eligibility criteria, and will report this to the Call Center and advocate within 2 business days of receiving all necessary information. If a caller is determined to meet the basic eligibility, the Call Center will be directed to contact the client for Screening and Assessment. If a caller is determined to not meet the basic eligibility for Family Assistance and Resource Group services at this time, the caller and/ or their advocate will be provided referral information to other resources.

1.16 Grievances with Call Center Assessment Determination

Any Family Assistance and Resource Group partner agency case worker may file an appeal with the Family Assistance and Resource Group Program Manager to re-assess a client for whom the VI-SPDAT completed by the Call Center is believed to be incorrect. A grievance must include the rationale for reassessment.

Re-assessments will be provided when an agency or client can provide additional documentation, case records, diagnosis information, or other information that would impact the client's assessment score. The Family Assistance and Resource Group Program Manager will make final determinations on granting a re-assessment.

In the case the Family Assistance and Resource Group Program Manager approves a re-assessment, the client will be asked to complete the Service Prioritization and Decision Assistance Tool (SPDAT), which draws on additional

background information, documents, and information provided by professionals working with the client to provide a more comprehensive assessment than the VI-SPDAT. The SPDAT is completed by trained and approved personnel only. The Family Assistance and Resource Group Program Manager will assist the client in connecting to an approved assessor.
After the SPDAT has been completed, the Family Assistance and Resource Group Program Manager will evaluate the results to determine if a change in referral prioritization is needed. If so, the Family Assistance and Resource Group Program Manager will adjust referral processes as needed to accommodate the new prioritization level of the client.

1.17 Emergency Hotel Assistance Policy

Family Assistance and Resource Group will assist in subsidizing temporary hotel/ motel accommodations for households who have met the basic eligibility for Family Assistance and Resource Group services, have completed an Assessment, and are in one of the following situations:

- The household is unable to safely stay in an emergency shelter due to a medical issue (physical/ mental health or developmental disability) present in any member of the household that has been confirmed by a medical professional or as informed by Family Assistance and Resource Group service providers with knowledge of the household's history. In cases where medical need is unclear, the Family Assistance and Resource Group Program Manager will make the final determination on whether Family Assistance and Resource Group will provide hotel subsidy.

In general, callers must be confirmed as street homeless or callers must be getting discharged from a public institution (in which they stayed for less than 90 days) directly to street homelessness/ shelter in order to qualify for hotel/ motel subsidy.
Housing Resource Center Supervisors will approve or deny requests for hotel subsidy. When there is a question regarding whether a client meets the definition above, the Housing Resource Center Supervisor will contact the Family Assistance and Resource Group Program Manager for final approval/ denial.
Households receiving hotel subsidy may be prioritized for other housing services (such as Rapid Re-Housing) through Family Assistance and Resource Group above others with a higher acuity, in order to provide more adequate/ appropriate living environments for these vulnerable households and in order to reduce the cost of extended hotel subsidies. The Housing Resource Center Supervisor will determine the prioritization level of these clients based on the client's needs, situation, and availability of other services at the HRC.
Hotel stays are expected to last no more than 30 days. It is expected that the assigned HRC will prioritize the household in resolving their homelessness in less than 30 days through increased supports (such as more case management hours). If the household will need a hotel stay for longer than 30 days, approval from the Family Assistance and Resource Group Program Manager is required.
Family Assistance and Resource Group does not provide hotel/ motel subsidy if shelter space is needed but unavailable, or for persons who refuse to enter an emergency shelter for non-medical reasons; i.e. refusal to leave a non-service animal, refusal to enter a congregate living facility, or refusal to accept shelter in a specific location.

1.18 Payment of Hotel Subsidies

Housing Resource Centers will provide hotel subsidy for up to 30 days for clients who meet the eligibility for this service as defined in the Emergency Hotel Assistance policy.
Within two business days of providing hotel subsidy, all households must sign a Housing Stability Plan with the Housing Stability Coach that outlines the terms of continued financial assistance from the Housing Resource Center in order to continue to receive hotel subsidy. Family Assistance and Resource Group hotel subsidy is always dependent upon a household's inability to pay for the hotel using their own funds; if it is determined that

a client has the assets available to them to pay for the hotel (such as sufficient income and/or savings), the Housing Resource Center Supervisor may terminate or limit the hotel subsidy.
The Housing Resource Center Supervisor may refuse to continue or take over hotel subsidy payments for any household referred by a partner organization that does not meet the criteria established in the Emergency Hotel Assistance policy.
Hotel subsidies are expected to be paid for by public funds for the first 30 days. If the household will need a hotel subsidy for longer than 30 days, approval from the Family Assistance and Resource Group Program Manager is required. Hotel subsidies past 30 days are paid for through the Family Assistance and Resource Group Initiative Fund.

1.19 Hotel Subsidy Terms and Length of Service

Households receiving hotel/ motel subsidy from Family Assistance and Resource Group will be required to work with a Family Assistance and Resource Group case manager towards obtaining permanent housing. Households will be required to help develop and sign a Housing Stability Plan outlining specific goals and actions to obtain permanent housing in order to continue to qualify for hotel subsidy. Hotel subsidy and corresponding Housing Stability Plans are generally developed in one-week increments, though there is no limit on the length of time a household may receive hotel subsidy, so long as the household is meeting the terms of this service as defined in their Housing Stability Plan and so long as the household continues to qualify for Family Assistance and Resource Group hotel subsidy.
If a household is not meeting the terms of their Housing Stability Plan, as documented by case notes or other documentation maintained by their case worker, the Housing Resource Center Supervisor will end the hotel subsidy and provide the household with 48 hours' notice in writing of the end date of the hotel subsidy. Any household whose hotel subsidy has been ended may appeal to the Family Assistance and Resource Group Program Manager according to the policy on Grievances with Hotel Subsidy Discharge.

1.20 Damage Incurred by Clients at Hotels

At times, households receiving hotel subsidy from Family Assistance and Resource Group may incur damages at the hotel. In order to maintain positive relationships with local hotel vendors, Family Assistance and Resource Group will provide funds to address damages incurred by households receiving hotel subsidy during the time of their subsidized stay. Family Assistance and Resource Group will provide up to $500 per household, per hotel stay, to pay for damages incurred by the household. (Hotel stay is defined as one continuous episode of residing in any hotel subsidized by Family Assistance and Resource Group.) Family Assistance and Resource Group will not pay for expenses unrelated to damage incurred by the household or that exceed a reasonable amount needed to address the damage.
Households incurring excessive damage to a hotel room may have their hotel subsidy from Family Assistance and Resource Group ended in the following instances:
- Damages were the result of persons in the room other than members of the household;
- Excessive damage was caused to the room as a result of actions taken by the household that were unrelated to medical issues/ accidents; or
- Household has caused significant damage in more than three separate incidents that were not a result of a medical issue/ accident.

Housing Resource Center Supervisors will make determinations on whether to end hotel stays based on damaged incurred. Any household whose hotel subsidy has been ended may appeal to the Family Assistance and Resource Group Program Manager according to the policy on Grievances with Hotel Subsidy Discharge.

1.21 Grievances with Hotel Subsidy Discharge

Any household for whom Family Assistance and Resource Group hotel subsidy is ended may appeal this decision by writing to the Family Assistance and Resource Group Program Manager within 10 business days of the last day of hotel subsidy. The Family Assistance and Resource Group Program Manager will review the case and make a final determination on whether to reinstate the hotel subsidy or to confirm the discharge. The Family Assistance and Resource Group Program Manager will inform the client of the decision within 2 business days of receiving the household's written appeal.

1.22 Approval of Hotel Subsidy during Code Blue

During times when LinnCounty Department of Public Safety declares a Code Blue, emergency shelters increase capacity in order to offer safety, food, and clothing to those in need. If there are times when Code Blue capacity has reached a maximum in all LinnCounty emergency shelters, the Family Assistance and Resource Group Street Outreach provider may approve a temporary hotel subsidy for street homeless households during declared Code Blue nights. In these instances, the Street Outreach director will make a final determination of the approval of a hotel subsidy based on case knowledge of the household, knowledge of the lack of shelter availability, and an assessment of the household's need. When approved, hotel subsidy will only cover the time period when there is a declared Code Blue.

1.23 Office of Jackson Street Youth Mandated Childline Reporting Policy

If any Family Assistance and Resource Group provider has a concern about the immediate safety of a child, local police should be contacted by dialing 9-1-1. If the police determine that a call to Linn County's Office of Jackson Street Youth is necessary, the police will make a report. If there are no other safety concerns other than homelessness, Policy 1.23 must be followed.

1.24 Reports of Street Homelessness of Families with Children Under 18

In the event that a household with children under the age of 18 reports street homelessness for the children to the Call Center or any other Family Assistance and Resource Group provider, the Call Center Navigator or Family Assistance and Resource Group provider will first follow the procedure to assess the household and refer the household to the Street Outreach navigator . The Call Center Navigator or Family Assistance and Resource Group provider must then call the 24-hour Street Outreach telephone line to give verbal report of children sleeping in a place not meant for human habitation. Street Outreach, upon making a determination and verification of homeless status, will file a child line report and call Office of Jackson Street Youth's administrative office to make a report if the following three conditions are met:

- The household is confirmed literally homeless
- There is no immediate emergency shelter space for the family that night
- It has been established that there is no safe place for the children to reside temporarily until shelter space is available

The Street Outreach Case Manager will provide the referral status, emergency shelter information, and other information as requested by the Office of Jackson Street Youth's administrator in these instances. The Office of Jackson Street Youth will provide a follow-up email to the Family Assistance and Resource Group Program Manager to coordinate case planning the next business day. This email will include any information regarding the Office of Jackson Street Youth's further involvement in the case.

1.25 Eligibility and Prioritization of Households Refusing Emergency Shelter

Any household has a right to refuse entry into an emergency shelter for any reason without this refusal affecting their ability to access other housing services through Family Assistance and Resource Group. Households that refuse emergency shelter will remain eligible for any Family Assistance and Resource Group service for which they meet eligibility requirements, and will be prioritized for these services in accordance with Family Assistance and Resource Group's prioritization policies.

1.26 Entering Non-Identifying Information into FAC Data Systems

Every client has the right to choose to opt out of sharing their personally-identifying information within the FAC Data Systems. "Personally-identifying information" refers to the combination of the person's name and date of birth or their full social security number. If a client chooses to opt out of sharing personally-identifying information, then the agency staff person will use the standardized convention for entering de-identified information into CMS HS, which together is known as the client's FAC Code. The staff will record the FAC Code on the client's Release of Information where indicated. The FAC Code will be used in all FAC Data Systems in place of the client's name.

It is the participating agency's responsibility to accurately update and otherwise maintain the FAC Data System records of any client choosing to opt out of entering personally-identifying information. Agencies must establish internal policies ensuring the FAC Code is properly recorded and maintained in client's file such that a supervisor would be able to locate the FAC Code within the client's file at any time.

Client Profile Data Element	**De-Identified Response**
First Name	Last 4 digits of client's social security number
Last Name	CMS-generated Unique Identifier
Quality of Name	Client Refused
Social Security Number	000-00-0000
Quality of Social Security Number	Client Refused
Date of Birth	1/1/year of birth
Quality of Date of Birth	Approximate or Partial DOB Reported

1.27 Non-Discrimination Policy

Family Assistance and Resource Group Coordinated Entry, housing and homeless service providers must be in compliance with all applicable civil rights and fair housing laws and requirements. Recipients and subrecipients of CoC Program and ESG Program funded projects must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws as specified at 24 C.F.R. 5.105(a), including, but not limited to the following: Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status; Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance; Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color or national origin under any program or activity receiving Federal financial assistance; and Title II of the Americans with Disabilities Act prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance. Title III of the Americans with Disabilities Act prohibits private entities that own,

lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability. In addition, HUD's Equal Access Rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or

HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program. The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA, see 24 CFR 574.603.

1.28 Gender Identity Non-Discrimination Policy

Family Assistance and Resource Group clients shall be treated according to their self-reported gender identity regardless of appearance, genital or other physical characteristics, or inconsistent legal documentation (such as a driver's license).

Transgender people presenting for intake shall not to be turned away or referred to another shelter or program because of their transgender status, the length or extent of their gender transition, and/or because they do not meet the expectations of what a man or woman is supposed to look like.

Private information, such as medical information about a Family Assistance and Resource Group client's transgender status and/or transition, is confidential.

Staff shall address Family Assistance and Resource Group clients with names, titles, pronouns, and other terms consistent with their gender identity. For example:

• A transgender woman shall be referred to by her preferred name and female pronouns.

• A transgender man shall be referred to by his preferred name and male pronouns.

Family Assistance and Resource Group does not tolerate verbal or physical harassment of any client, including that directed at transgender clients. If a transgender client experiences harassment, the incident of harassment shall be reported to a staff member as soon as possible, and the staff shall take immediate action to ensure the safety of the transgender client. If harassment is committed by staff member(s), the incident of harassment shall be reported to the appropriate supervisor(s) as soon as possible and the supervisor(s) shall take immediate action to ensure the safety of the transgender client. All incidents of harassment must be documented in writing.

It is impermissible for Family Assistance and Resource Group clients to assert a gender identity solely for fraudulent or other improper purposes. All assertions by Family Assistance and Resource Group clients of their gender identity will be presumed accurate and shall not be questioned by staff without a credible, objective, demonstrable basis. When a Family Assistance and Resource Group client's gender identity is questioned, staff who has been trained on the program's policy and practices with regard to transgender clients:

• May initiate a conversation with the client in order to evaluate the client's gender identity and any other gender-related concerns;

• May request documentation supporting the client's stated gender identity including a letter from a medical provider, therapist, social worker, member of the clergy, etc. * Note: documentation of gender identity for transgender clients is not expected or required in the majority of cases – this provision shall only be triggered upon a credible, objective, demonstrable basis for calling into question the client's stated gender identity*;

• Any evidence supporting the fact that the client's stated gender identity is sincerely held as part of a person's core identity, including evidence demonstrating that the client presents and lives consistent with the stated gender identity shall be accepted by Family Assistance and Resource Group providers.

2. Prioritization Policies

2.1 Prioritization for Family Assistance and Resource Group Services

Family Assistance and Resource Group's goal is to be able to house every household that becomes homeless in LinnCounty within 30 days, and to provide emergency shelter from housing crisis immediately. Unfortunately, the need for these services exceeds Family Assistance and Resource Group's current capacity, and so Family Assistance and Resource Group must prioritize who receives services first.

Family Assistance and Resource Group is committed to the principle of serving the highest need households first, without preconditions or barriers to receiving those services, and to serve lower need households as resources allow. Family Assistance and Resource Group defines “highest need” both by a person’s current housing status and by a person’s vulnerability or acuity level (as determined by the results of Family Assistance and Resource Group’s common assessment tool, the VI-SPDAT, and by other presenting needs).
In general, households are prioritized for Family Assistance and Resource Group housing services in the following order:
1. Households that have been confirmed as category 1 homeless.
2. Households with the highest acuity as determined by the VI-SPDAT.

In general, households are prioritized for Family Assistance and Resource Group emergency shelter services in the following order:
1. Households that have been confirmed as category 1 homeless.
2. Households who are at greatest risk for severe health and safety consequences, as assessed by the Family Assistance and Resource Group Street Outreach.
3. Households with a pregnant head of household.
4. At times, a household may enter Family Assistance and Resource Group’s system who may need to be prioritized above others as a result of other factors not listed above, such as the safety of the individual or others in the individual’s presence or Family Assistance and Resource Group’s experience in serving the individual in the past. These additional factors are listed below for each service that Family Assistance and Resource Group provides.
Family Assistance and Resource Group maintains the right to adjust prioritization on a case-by-case basis as a result of the additional factors listed below, or other factors. The final determination on prioritization for Family Assistance and Resource Group services is made by the Family Assistance and Resource Group Program Manager. Changes in prioritization will be communicated with Family Assistance and Resource Group provider agencies and referral partners regularly to ensure transparency in the prioritization process.
Grievances with any prioritization decision made by the Family Assistance and Resource Group Program Manager should be sent to the Family Assistance and Resource Group Senior Manager for review.

2.2 Prioritization for Emergency Shelter: Additional Considerations

Prioritization for emergency shelter services, including hotel/ motel subsidy for households with medical needs, may factor in the following in addition to the prioritization factors listed above:
1. Family households with a pregnant head of household.
2. Single adult households with medical conditions leading to frailty.
3. Households being discharged from a public institution directly to the street.
4. Households residing in Code Blue shelter at the end of Code Blue season.
5. Households who were unable to be diverted through Housing Counseling.
In some instances, a household in this situation may be prioritized for entry into a shelter (or hotel subsidy) before services are provided to someone who is street homeless and/or who has a higher acuity on the VI-SPDAT.

2.3 Prioritization for Rapid Re-Housing

Prioritization for Rapid Re-Housing may also factor in the following:
1. Households who are street homeless but who refuse emergency shelter due to untreated mental health issues or other good cause.
2. Households receiving emergency hotel subsidy due to medical reasons.
3. Households with an identified plan to move into permanent housing with limited (one-time) financial assistance.
In some instances, a household in any of the above situations may be prioritized for Rapid Re-Housing services over someone who is street homeless or in shelter and/or who has a higher acuity as indicated by the VI-SPDAT.

2.4 Prioritization for Transitional Housing

Prioritization for transitional housing may also factor in the following:

1. Household size, particularly if a larger unit becomes available.
2. Significant barriers in obtaining permanent housing in the household's own name.
3. Households where the Head of Household is experiencing a significant but temporary medical condition or other hardship that restricts their ability to immediately increase income.

2.5 Prioritization for Permanent Supportive Housing

Prioritization for permanent supportive housing is overseen by the Permanent Housing Advisory Team and policy.

3. Street Outreach Policies

3.1 Confirming Street Homelessness

Family Assistance and Resource Group's priority is to serve persons who are living outdoors, in their cars, in tents, or in other places not meant for human habitation. Because Family Assistance and Resource Group's initial contact with most persons is through self-report of current housing location, and because Family Assistance and Resource Group has experienced that self-reporting of street homelessness is often inaccurate, a person reporting street homelessness to the Call Center must be confirmed as such before being prioritized for Family Assistance and Resource Group emergency shelter services.

Confirmation of street homelessness is conducted by the Street Outreach navigator . The Street Outreach navigator will confirm street homelessness by verifying that an individual or household's primary nighttime residence is one of the following locations:

- Anywhere outdoors, such as a park, forest, a tent or campground, or porch
- A car/ vehicle
- An abandoned or condemned building, or a building in which there is no heat or electric
- A hallway, transportation center, 24-hour store/ building, or similar

Persons who are experiencing homelessness may move frequently, and so the Street Outreach navigator will confirm anyone as street homeless for whom sleeping in any of the above locations is a frequent or sustained activity, even if this is interrupted by periods of sleeping in non-street homeless locations (such as a family or friend's apartment or a hotel).

To the extent feasible, the Street Outreach navigator is expected to confirm street homelessness by witnessing the household actually sleeping outdoors. If this is not possible, the Street Outreach navigator is expected to meet the household at the location where they are reporting sleeping overnight before confirming street homelessness.

3.2 Services Provided to Street Homeless Households

The Street Outreach navigator will provide referrals to services and supplies for homeless persons with whom they come into contact, whether they are confirmed as street homeless or not. These referrals will include:

- Basic needs- food pantries, community meals, clothing, supplies
- Day shelter
- Mobile mental health services, such as Critical Time Intervention or Adult Mobile Crisis
- Emergency shelters for non- Family Assistance and Resource Group participating shelters in LinnCounty or a person's county of origin
- Medical services
- Referral for and transportation to hospital if needed youth
- County Assistance Office for public benefits
- LinnCounty Code Blue, when available
- Transportation to a Family Assistance and Resource Group shelter, if shelter space is available (persons who are confirmed as street homeless only)

3.3 Confirming Street Homelessness of Families with Children Under 18

In the event that a household with children under the age of 18 is confirmed as literally homeless, and there is no timely family shelter bed availability, and safe, temporary, alternative housing situations cannot be found for the children until shelter space is available, the Street Outreach Team Member will call the Office of Jackson Street Youth's administrative office to make a report and will file a childline report. The Street Outreach Team Member will provide the referral status, emergency shelter information, and other information as requested by the Office of Jackson Street Youth's administrator. The Office of Jackson Street Youth will provide a follow-up email to the Family Assistance and Resource Group Program Manager to coordinate case planning the next business day. This email will include any information regarding the Office of Jackson Street Youth's further involvement in the case.

3.4 Street Outreach Caseload

Once Street Outreach meets with a household to determine literal homeless status, Street Outreach must enroll the household into the Street Outreach Program in CMS. The household will remain on the Street Outreach's caseload until all service referrals have been made and one of the following happens:

- The household enters shelter (participating or non-participating with Family Assistance and Resource Group)
- The household enrolls in Rapid Re-Housing or another housing program (participating or non-participating with Family Assistance and Resource Group)
- The household self-resolves their homelessness for 7 or more consecutive nights
- The household enters a treatment facility for a period more than 5 days
- Contact is lost for more than 2 weeks

Street Outreach will remain in contact at least weekly with any household enrolled into the Street Outreach Program and confirmed as experiencing literal homelessness. The program enrollment will be closed when one of the above listed events happen.

4. Housing Counseling Policies

4.1 Housing Counseling Eligibility

Households are eligible for Housing Counseling case management services if they are:

- Doubled Up/ Couch-Surfing: An individual or household temporarily living in the home(s) of others due to economic hardship and who must leave this housing situation immediately.
- Living in a Hotel/Motel: An individual or household living in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals.

4.2 Case Management for Housing Counseling Clients

Case management for most Housing Counseling clients will be provided in a single phone call or in-person meeting. Case management services are not expected to be provided for longer than the time needed to develop a plan to maintain permanent housing, and the time needed to provide financial assistance as appropriate. Case managers providing Housing Counseling to clients are not required to provide follow-up services, unless stipulated by a grant agreement. If Housing Counseling is unsuccessful and a household needs to be referred to emergency shelter, the Housing Counseling program will remain open and contact between the Case Worker/Housing Stability Coach will happen at least weekly until the household is able to enter shelter.

4.3 Financial Assistance for Housing Counseling Clients

In Family Assistance and Resource Group's experience, most households receiving Housing Counseling will not need financial assistance to be diverted from shelter. However, some households may need some limited financial assistance in order to successfully maintain housing, as determined through their Housing Counseling planning sessions with their case manager.

Financial assistance may be provided to Housing Counseling clients that meet the eligibility requirements for Housing Counseling financial assistance as defined in the policy on Housing Counseling Eligibility and when the following conditions are met:

• Head of Household is a LinnCounty resident, per the County Residency Policy.
• Household income is at or below 30% of the Area Median Income.
• The client meets in-person with the Housing Counselor and provides all documentation necessary to process a payment according to Family Assistance and Resource Group's invoicing policies and all applicable grant/funding requirements.
• The client completes and signs a Housing Stability Plan with the case manager, documenting the client's action steps to gain housing stability and receive financial assistance. Any action steps required by the client must be taken prior to payment authorization.
• The financial assistance provided is one-time assistance only, and payment of this assistance will resolve the immediate housing crisis and allow the household to maintain housing for 30 days.
• Clients receiving financial assistance to move into new units must first be approved by HRC supervisor. If approved to be rehoused, the Housing Counselor and client must be able to provide all required documentation to process a move-in under Family Assistance and Resource Group's Rapid Re-Housing program, and must be able to demonstrate that the unit is affordable based on their current income. Clients may be eligible for security deposit and first and last month's rent, depending on need.
• While there is no dollar limit on the amount of assistance a client may receive (unless specified by a grant), case managers are required to follow the principles of progressive engagement to provide the least amount of resources necessary to resolve the immediate crisis. This may include: requiring a client contribution, partnering with other local organizations to combine payments, and helping clients establish payment plans. The Family Assistance and Resource Group Program Manager may request additional support for a request and/or deny a request for payment if the request appears unreasonable.

Housing Resource Centers and other organizations approved to access the Family Assistance and Resource Group Initiative Fund will use those funds to process Housing Counseling payments, following the process for requesting reimbursement for the Family Assistance and Resource Group Initiative Fund, except for instances in which the HRC supervisor approves the re-housing of the client. In these cases, all policies and procedures under Rapid Rehousing must be followed.

Family Assistance and Resource Group emergency shelters providing Housing Counseling will contact the Family Assistance and Resource Group Program Manager to arrange for payment of Housing Counseling client subsidies in the event that financial assistance is needed for a Housing Counseling client. Emergency shelters will then be connected to a Housing Resource Center to arrange payment. In this instance, the emergency shelter is responsible for compiling and providing all of the documentation necessary to process the payment to the Housing Resource Center before payment is authorized by the Housing Resource Center.

4.4 Eligible Activities/ Payments Under Housing Counseling

Housing Counseling clients that meet the criteria established under the policy on Financial Assistance for Housing Counseling Clients are eligible to receive the following types of payments. HRC Supervisors must also reference the Invoicing and Eligible Costs Checklist Form (Form 5.36) to ensure invoicing compliance.

• From publically-funded budgets or specialized grants: o Security Deposit, First Month, Last Month Rent for move-in to a new unit

o Utility Deposit for move-in to a new unit

• From the Family Assistance and Resource Group Initiative Fund: o Birth certificate or ID replacement costs
o Job training program costs (fees, uniforms and equipment)

o Car repair/car insurance
o Child care/day care services
o Extermination (if not covered by public dollars or lease agreement)
o Food gift cards
o GED and College Entry testing costs
o Renters insurance
o School uniforms and books
o Transportation costs for housing, health, child care, employment and job training appointments (bus tokens, train passes, taxi rides, etc.)
o Air conditioning unit (if needed for medical reasons)

Documentation requirements are covered under the Invoicing & Eligibility Cost Checklist Form.

4.5 One-Time Assistance to Move Residents Out of County

One-time payments to Housing Counseling clients to move to permanent housing outside of LinnCounty are allowable expenses under the Family Assistance and Resource Group Initiative Fund with prior approval from the Family Assistance and Resource Group Program Manager, so long as the client meets the eligibility criteria for Housing Counseling financial assistance.

5. Emergency Shelter Policies

5.1 Emergency Shelter Eligibility

In order to be eligible for emergency shelter, a household must be able to provide documentation of the following:
• Homeless, as defined by HUD Category 1, 2, or 4: o Literally Homeless (Category 1): Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: Has a primary nighttime residence that is a public or private place not meant for human habitation;
 Is living in a 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 and local government programs); or

- Is exiting an institution where (s)he has 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
- At Imminent Risk of Homelessness: Individual or family living in the home of another or living in a hotel or motel not paid for by a charitable organization who will imminently lose their primary nighttime residence, provided that: Residence will be lost within 14 days of the date of application for homeless assistance;
- No subsequent residence has been identified; and
- The individual or family lacks the resources or support networks needed to obtain other permanent housing
    - Fleeing/ Attempting to Flee Domestic Violence (Category 4): Any individual or family who: Is fleeing, or is attempting to flee, domestic violence;
- Has no other residence; and
- Lacks the resources or support networks to obtain other permanent housing

Emergency Shelters must collect documentation to determine that the household meets the eligibility criteria as defined above, following the policy on Documentation of Homeless Status, within 3 business days of enrollment into shelter.

Family Assistance and Resource Group emergency shelters may also maintain additional eligibility criteria, so long as these eligibility criteria comply with Fair Housing law, are documented in the program's policies and procedures, and have been shared with Family Assistance and Resource Group's Operations Team and Call Center.
Family Assistance and Resource Group encourages all emergency shelters to maintain as few eligibility criteria as possible in order to maintain low barriers to accessing emergency shelter.

5.2 Documentation of Homeless Status

In order to ensure that resources are provided to the most vulnerable populations, and that all persons served comply with Family Assistance and Resource Group's policies and federal funding requirements, all Family Assistance and Resource Group programs requiring Documentation of Homeless Status (Emergency Shelter, Rapid Re-Housing, Transitional Housing, and Permanent Supportive Housing) must collect documentation of a household's homeless status prior to program enrollment. Documentation of Homeless Status must be maintained in client files and will be reviewed during monitoring visits, in the case of client appeals, or otherwise as requested by the Family Assistance and Resource Group Operations Team.
Third-party documentation of homeless status is always preferred to self-certification, and should be obtained in most cases.

Homeless Category	**Recordkeeping Requirements**
Category 1: Literally Homeless	• Written (HMIS record or standardized letter (Form 3.2)) observation by the street outreach worker; or • Written (HMIS record of or standardized letter (Form 3.2)) referral by another housing or service provider, or • Written certification by the individual or head of household seeking assistance that (s)he was living in the streets or in shelter; • For individuals exiting an institution- one of the forms of evidence above documenting that the individual was living on the street or in an emergency shelter immediately prior to entering the institution, and that the individual was living in the institution for less than 90 days, and o Discharge paperwork signed by the Institution Social Worker, and o Written record of housing plan created by the Institution Social Worker and Family Assistance and Resource Group confirming Family Assistance and Resource Group assistance
Category 2: Imminent Risk of Homelessness	• For individuals and families leaving a hotel or motel – evidence that they lack the financial resources to stay, or • Written certification from the leaseholder/ homeowner that the family must leave the residence • Written certification (HMIS Housing Counseling record) confirming that no subsequent residence has been identified, and • Written certification (HMIS record) that the household lacks the financial resources and supports necessary to obtain permanent housing.
Category 4: Fleeing/	*For victim service providers:* • An oral statement by the individual or head of household seeking

Attempting to Flee Domestic Violence	assistance which states: they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker. *For non-victim service providers:* • Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified, and • Certification by the individual or head of household that no subsequent residence has been identified, and • Self-certification or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

5.3 Gender Identity Non-Discrimination in Emergency Shelter

All shelter clients, including transgender people, shall be placed in dormitory facilities based on their self-reported gender identity regardless of appearance, genital or other physical characteristics, inconsistent legal documentation, or concerns (real or perceived) about objections or complaints of other clients.
All shelter clients, including transgender people, who have privacy concerns shall be directed to spaces, where or when available, that allow for greater privacy and spaces that provide equivalent accommodations to those provided in the sleeping dormitories.
• The use of private rooms shall not be reserved solely for transgender individuals.
• A private room may be requested and utilized for any shelter client including but not limited to transgender clients who request additional privacy.
• The unavailability of alternative space shall not be a basis for altering a transgender client's sleeping accommodation.

All shelter clients, including transgender people, who have safety concerns shall be directed to beds or private rooms, where or when available, with equivalent accommodations that are closer to staff.
• The use of private rooms shall not be reserved solely for transgender individuals.
• A private room may be requested and utilized for any shelter client including but not limited to transgender clients who request additional privacy because of safety concerns in the main sleeping area.
• The unavailability of such accommodation shall not be a basis for altering a transgender client's sleeping accommodation.

All shelter clients, including transgender people, shall have access to bathrooms, showers, and all other facilities/programs separated by sex consistent with their gender identity regardless of appearance, genital or other physical characteristics, or inconsistent legal documentation.
Some shelter clients may express discomfort regarding a transgender person sleeping in or using the facility that is consistent with the transgender person's gender identity. Another client's discomfort is not a reason to deny access to equal treatment for the transgender person. Shelter staff shall work with shelter clients to address the discomfort and to foster understanding of gender identity for the purpose of creating a shelter environment that respects and values all shelter clients.

5.4 Year-Round Emergency Shelter Case Management

The common purpose of Family Assistance and Resource Group's year-round emergency shelters is to provide a safe place to sleep while empowering people to connect to permanent housing as quickly as possible.
Year-round emergency shelter case management is provided consistent with each shelter's internal policies and procedures; however, Case Management services must meet the minimum standards as described below in order to qualify as an allowable activity under Family Assistance and Resource Group grants:
1. Initial meeting with all enrolled households staying longer than 5 days. Case managers must meet with all clients residing in the shelter longer than 5 days* to assess the client's current housing situation and complete the following: a. Household budget
b. Service Prioritization and Decision Assistance Tool (SPDAT)
c. Housing Stability Plan

2. At least weekly one-on-one case management thereafter to help the household obtain permanent housing as quickly as possible. Case management must follow the goals outlined in the Housing Stability Plan to obtain permanent housing. Case managers are encouraged to use skills like motivational interviewing, housing-focused case management, and progressive engagement to assist the client in obtaining permanent housing while using the least amount of system resources necessary. Case management should focus on goals related to obtaining permanent housing, obtaining mainstream benefits, connecting to community and other supports that will help maintain housing stability long-term, and increasing income.

*Shelters should complete this with clients staying longer than 5 days at minimum- a shelter may choose to complete these items with all households prior to 5 days passing.

5.5 SPDAT Determinations and Shelter Housing Stability Planning

Family Assistance and Resource Group's emergency shelters are united in the goal to empower households to move to permanent housing as quickly as possible. To do so, Emergency Shelters use Family Assistance and Resource Group's case management planning tools to assess, identify strengths and barriers to housing stability, and create a plan for gaining and obtaining permanent housing as quickly as possible.
Emergency Shelters will, at their first meeting with a resident, complete three tools to assist in developing a plan towards housing stability- the budget, SPDAT, and Housing Stability Plan.
The results of the SPDAT will inform Housing Stability Planning in the following ways:
1. Households scoring into the low acuity category will be eligible for one-time assistance to move out of shelter. Shelters will complete a Housing Stability Plan that helps the household create a plan for move-out, which is financially coordinated through one of three Family Assistance and Resource Group Housing Resource Centers.
2. Households scoring into the medium acuity categories will be eligible for enrollment into the Rapid Re-Housing Program through one of Family Assistance and Resource Group's three Housing Resource Centers. Shelters will complete a Housing Stability Plan that helps the household prepare for the Rapid Re-Housing program.
3. Households scoring into the high acuity categories will be eligible for enrollment into the Permanent Supportive Housing Program through one of Family Assistance and Resource Group's Permanent Supportive Housing providers, as coordinated through the Department of Behavioral Health and Developmental Disabilities. Shelters will complete a Housing Stability Plan that helps the household prepare for Permanent Supportive Housing. If PSH is not available, shelters will also help clients prepare for the Rapid Re-Housing program as a temporary solution to their homelessness.

In all cases, emergency shelter case workers are encouraged to discuss the household's score on the SPDAT assessment and the options available to the households as result of that score. Households that are not eligible for more than one-time assistance, for example, should be told this as part of the Housing Stability Planning

discussion. In all cases, shelter case workers must help their clients identify reasonable plans to gain housing stability based on what is available to them through Family Assistance and Resource Group.

5.6 Move-Out Assistance for Households in Shelter

Some households may need limited financial assistance in order to successfully move out of shelter, as determined through their Housing Stability Plan created with their shelter case manager.
Time-limited assistance to move out of shelter may be provided to clients in shelter when the following conditions are met:

• The client provides all documentation necessary to process a payment according to Family Assistance and Resource Group's invoicing policies and all applicable grant requirements.
• The client completes and signs a Housing Stability Plan with the shelter case manager, documenting the client's action steps to gain housing stability and receive financial assistance. Any action steps required by the client must be taken prior to payment authorization.
• The financial assistance provided is one-time assistance only, and payment of this assistance will resolve the immediate housing crisis and allow the household to maintain permanent housing for 30 days.
• Clients moving into new units must be able to provide all required documentation to process a move-in under Family Assistance and Resource Group's Rapid Re-Housing program, and must be able to demonstrate that the unit is affordable based on their current income. Clients may be eligible for security deposit, first, and last month's rent, depending on need.
• While there is no dollar limit on the amount of assistance a client may receive (unless specified by a grant), case managers are required to follow the principles of progressive engagement to provide the least amount of resources necessary to resolve the immediate crisis. This may include: requiring a client contribution, partnering with other local organizations to combine payments, and helping clients establish payment plans. The Family Assistance and Resource Group Program Manager may request additional support for a request and/or deny a request for payment if the request appears unreasonable.

Family Assistance and Resource Group emergency shelters will contact the Family Assistance and Resource Group Program Manager to arrange for payment of one-time assistance. Emergency shelters will then be connected to a Housing Resource Center to arrange payment. In this instance, the emergency shelter is responsible for compiling and providing all of the
documentation necessary to process the payment to the Housing Resource Center before payment is authorized by the Housing Resource Center.

5.7 Eligible Activities/ Payments for Households in Shelter

Households in Emergency Shelter that meet the criteria established under the policy on Financial Assistance for Emergency Shelter Households are eligible to receive the following types of payments. HRC Supervisors must also reference the Invoicing and Eligible Costs Checklist Form (Form 5.36) to ensure invoicing compliance.

• From publically-funded budgets: o Security Deposit, First Month, Last Month Rent for move-in to a new unit
o Utility Deposit/ Utility Payment
o Payment of utility/ rental arrearages not to exceed 6 months' of rent/ utility usage
o Hotel/ motel voucher (payment from public sources may not exceed 30 days)
o Moving cost assistance (truck rental, moving company, storage fee of up to 3 months)

• From the Family Assistance and Resource Group Initiative Fund: o Birth certificate or ID replacement costs
o Car repair/car insurance
o Job training program costs (fees, uniforms and equipment)
o Child care/day care services
o Extermination (if not covered by public dollars or lease agreement)

o Food gift cards
o GED and College Entrance testing costs
o Motel/hotel stay after 30 days (needs approval by Family Assistance and Resource Group Program Manager)
o School uniforms and books
o Transportation costs for housing, health, child care, employment and job training appointments (bus tokens, train passes, taxi rides, etc.)

Documentation requirements are covered under the Invoicing and Eligible Costs Checklist Form.

5.8 One-Time Assistance to Move Residents Out of County

One-time payments to shelter clients to move to permanent housing outside of LinnCounty are allowable under the Family Assistance and Resource Group Initiative Fund with prior approval from the Family Assistance and Resource Group Program Manager, so long as the client and payment meets the eligibility criteria for financial assistance. Note that out of county residents served in shelter temporarily may be provided one-time assistance to move to their county of origin.

5.9 Overriding the SPDAT Score Guidance

At times, the SPDAT score a household receives may provide inappropriate guidance on the type and duration of assistance that should be provided, based on the household's unique needs. This may mean that low acuity clients may need more supportive services to move out of shelter than what can be provided through one-time assistance. Conversely, it may be that a medium or high acuity client can maintain permanent housing without the amount of supportive services provided in Rapid Re-Housing or Permanent Supportive Housing.
In cases where a shelter case manager has identified that a low acuity household will need more supportive services to move out of shelter, the Shelter Supervisor will review and approve the determination. Then, the Shelter Supervisor will contact the Family Assistance and Resource Group Program Manager for case review. The Family Assistance and Resource Group Program Manager will make the final determination on whether the household can be referred to the Rapid Re-Housing program based on the information provided by the Shelter Supervisor and any additional documentation needed. In this case, the Family Assistance and Resource Group Program Manager will send a referral for the household to the Community Queue.
In cases where a shelter case manager identifies that a medium acuity household will not need Rapid Re-Housing, the Shelter Supervisor will review and confirm the determination. In this case, the shelter case manager will not send a referral for the client to the Community Queue for Rapid Re-Housing. The Family Assistance and Resource Group Program Manager does not need to approve these cases.
In cases where a shelter or Rapid Re-Housing case manager identifies that a high acuity household will not need Permanent Supportive Housing, the case manager's supervisor will review and confirm the determination. In this case, the case manager will not send a referral for the client to the Permanent Supportive Housing Committee, or will contact the PSH Committee to retract the referral if one has already been sent. The Family Assistance and Resource Group Program Manager does not need to approve these cases.

5.10 Emergency Shelter Termination

Family Assistance and Resource Group's emergency shelters are committed to empowering families and individuals to regain permanent housing. As a result, in most cases emergency shelters are expected to exit their residents directly to housing (temporary or permanent), and not to street homelessness.
However, under certain conditions it may be appropriate for a shelter to immediately terminate a household from the shelter without arranging appropriate housing:
• A client/ head of household commits a criminal offense on shelter grounds;
• A client/ head of household threatens to imminently harm another shelter resident or shelter staff person;
• A client/ head of household physically harms another shelter resident or shelter staff person.

In all cases, the shelter must document the event in case notes and in accordance with shelter policies. It is expected that the shelter will contact local police to address the incident as these cases involve criminal acts.

5.11 Transfers Between Shelters due to Congregate Living Issues

Family Assistance and Resource Group's emergency shelters are committed to empowering families and individuals to regain permanent housing. As a result, in most cases emergency shelters are expected to exit their residents directly to housing (temporary or permanent), and not to another shelter or to homelessness. However, under certain conditions it may be appropriate for a shelter to recommend/ request to transfer a household from one shelter to another in order to relieve congregate living challenges and to provide a safe place for residents.

In these cases, emergency shelters may request to transfer households to another shelter by contacting the Family Assistance and Resource Group Program Manager. The Family Assistance and Resource Group Program Manager will determine if the reason for transfer is reasonable. If so, and if shelter space if available, the Family Assistance and Resource Group Program Manager will assist in transferring the household to another shelter provider. If space is not available, the shelter is responsible for maintaining housing for the household until other shelter space becomes available.

5.12 Documentation of Shelter Expectations & Household Violations

Family Assistance and Resource Group's emergency shelters are committed to empowering families and individuals by providing low-barrier entry into shelter and supporting the household to exit shelter to permanent housing. Family Assistance and Resource Group emergency shelters are discouraged from setting burdensome or elaborate "rules" for entering or being able to stay in shelter.

However, if the shelter wishes to establish certain expectations for shelter residents to abide by (in order to provide a safe, clean, and appropriate congregant living environment), Family Assistance and Resource Group requires that households receive a written copy of these expectations within 24 hours of entering shelter. If a household violates these expectations, the shelter must notify the household in writing of the violation. A copy of this written notice must be kept in the client's file. Additionally, the household must be offered the opportunity to provide a written response and/or a meeting with a shelter case manager or supervisor upon receipt of the written notification. These written responses or a record of the meeting must also be kept in the client's file.

It is the expectation that the Family Assistance and Resource Group emergency shelter provide due diligence to resolve the issue causing the violation. Written records must be kept in the client's profile of notifications given to the household, attempts at mediation & resolutions, and repeated attempts to resolve the issue. Emergency shelter termination due to violations of shelter expectations should be utilized only as a last resort. If a household must be terminated due to multiple documented instances of an inability to abide by shelter expectations, which result in a safety concern for the congregant living environment, the shelter must work with the household to discharge to a housing (permanent or temporary) destination. The emergency shelter must also contact the Family Assistance and Resource Group Program Manager to discuss the plan for termination, or to discuss the need for a transfer to another shelter.

6. Case Management Tools and Assessment Policies

6.1 Service Prioritization and Decision Assistance Tool (SPDAT)

The SPDAT is an evidence-informed approach to assessing an individual's or family's acuity. The tool, across multiple components, identifies the areas in the person/family's life where support is most likely necessary in order to avoid housing instability.

The SPDAT is used as both a prioritization tool and as a case management tool in Family Assistance and Resource Group. As a prioritization tool, the SPDAT is completed with households in Family Assistance and Resource Group emergency shelters by their shelter case worker to determine the most appropriate housing intervention for the household, and to determine the types of assistance that may be appropriate to assist the client. As well, the SPDAT is used to determine the household's priority in being served, in the event that there are not enough resources to serve all households in need of services.

As a case management tool, the SPDAT is used by case managers and households to identify areas of strength and challenge the household may face in maintaining housing stability, and to develop Housing Stability Plans that address the household's barriers. The SPDAT is intended to be completed frequently- during intake/ enrollment (or within 5 days of entering a shelter), and regularly thereafter. In emergency shelters, this may include updates every 30 days. In Rapid Re-Housing, this includes updates at least once every 90 days.

If a household is working with multiple Family Assistance and Resource Group providers, the case worker completing the SPDAT is expected to share the assessment with the household's other case workers. In many cases, it may be appropriate for a household's other case worker(s) to be interviewed or present during the completion of the SPDAT in order to ensure that the household's history is being reported accurately.

A copy of every SPDAT should be provided to the household and maintained in the client's case file. The SPDAT should be used in conjunction with the Household Budget to develop the Housing Stability Plan. It is expected that the components in the SPDAT that are identified as barriers to housing stability are addressed in the Housing Stability Plan. It is expected that as the components increase or decrease in acuity, a summary of these changes is reflected in the client's Housing Stability Plan, case notes, and Re-Assessment, as appropriate. In this way, the SPDAT should form the basis of case planning with Family Assistance and Resource Group clients.

Family Assistance and Resource Group case managers must be trained in use of the SPDAT before completing it with their clients.

6.2 Household Budget

An accurate understanding of a household's income and budget is a necessary tool to help clients maintain permanent housing. Prior to obtaining permanent housing, budgets help clients identify their housing price range based on their current income, and even the feasibility of renting a unit of their own if other options exist. After obtaining housing, budgets help clients plan for bill payments, keep track of expenses, and manage spending and saving.

Family Assistance and Resource Group's standard Household Budget provides a common template for use with all Family Assistance and Resource Group clients and their case managers. All Emergency Shelters and Rapid Re-Housing programs are required to develop and update a Household Budget with enrolled clients. In Shelter, Budgets should be updated any time income or expenses change. In Rapid Re-Housing, Budgets must be updated any time income or expenses change, or at least every three months during Re-Assessment.

Budgets should be reviewed with a client during development of the Housing Stability Plan, so that clients can set goals and action steps related to income/ benefits based on this budget.

In cases where a client is working with more than one Family Assistance and Resource Group provider, it is the responsibility of both provider staff to share the client's current budget with their other case worker(s).

6.3 Housing Stability Plans

One of Family Assistance and Resource Group's primary goals is to help people experiencing homelessness move to permanent housing as quickly as possible. To do so, case managers in all programs help clients establish goals

and action steps to obtain housing quickly, and to maintain that housing long-term. All Family Assistance and Resource Group Emergency Shelter Programs and Rapid Re-Housing Programs are required to create Housing Stability Plans for all enrolled clients, or whenever providing financial assistance to clients through Housing Counseling or Street Outreach.

The Housing Stability Plan is a standard template that allows case managers and clients to jointly identify goals and to detail the steps needed to achieve those goals. Goals identify the major achievements for gaining housing stability. Goals may be related to obtaining permanent housing, as well as other activities that will help the household maintain that stability long-term, such as connecting to health services, increasing income, or maintaining the terms of a lease. Goals are informed by the client's SPDAT, budget, and other related sources of information available to the client and the case worker. For each goal, additional action steps are created. Action Steps are specific tasks that the client and case manager will take to reach the goals identified in the plan, with due dates listed for each task. Both the client and the case manager must sign the Housing Stability Plan for it to be considered complete. It is the case manager's responsibility to ensure that the Housing Stability Plan is complete.

Typically, a Housing Stability Plan includes medium- to short-term goals and action steps that can be accomplished within the next 1-2 meetings, or covering the next 30 days. A new Housing Stability Plan is created once those action steps are completed.

Goals and action steps are developed jointly by clients and case managers. To the extent appropriate, clients should be setting their own goals for housing stability, with support from case managers so that they are reasonable, actionable, and timely. Case managers should use techniques such as motivational interviewing, active listening, housing-focused case management, and strengths-based case management to assist clients in developing goals and action steps.

In order to increase collaboration and consistency between the multiple providers a client may be working with, all Housing Stability Plans must be jointly created and/or shared with all case managers that are working with the same client in Family Assistance and Resource Group's network. For example- a Housing Resource Center coach must co-create and/or share the Housing Stability Plan of a client living in a Family Assistance and Resource Group shelter with the shelter case manager. This may include a joint session in which all case managers working with the client develop and sign the Housing Stability Plan together, or it may be that a primary case manager will develop the Housing Stability Plan with the client and then share it with the client's other case managers. In either case, it is the responsibility of every Family Assistance and Resource Group provider to make any Housing Stability Plan they create with a client available to the client's other case managers.

In cases where a client is being transitioned from one Family Assistance and Resource Group provider to another (such as from a Family Assistance and Resource Group shelter to a Housing Resource Center), it is the responsibility of both provider staff to 1) share any current plans currently in use by the client, and 2) coordinate Housing Stability Planning so that there is continuity in the case planning from one provider to the next. For example, if a client in shelter has a Housing Stability Plan in place with their shelter case manager at the time of their first Housing Resource Center appointment, the Housing Resource Center case manager should include the same goals on the HRC Housing Stability Plan as are already on the shelter Housing Stability Plan, to the extent appropriate.

The Housing Stability Plan template also allows clients and case managers to keep track of progress on meeting goals, which is a critical component of case management services provided under Family Assistance and Resource Group. Tracking progress allows clients and case managers to share in successes together, as well as to quickly identify and problem-solve areas of challenge. Tracking progress on the Housing Stability Plan occurs in two ways: first, the client tracks their own progress towards meeting goals in between case management appointments. Second, the case manager and client record when action steps and goals have been completed. Typically this will happen during the case management meetings. In this way, both clients and case managers have a written record of the client's progress on meeting goals.

The current Housing Stability Plan should be updated at every case management meeting between a client and a case manager until all action steps on the plan have been addressed. Updates would include recording the actions taken by the client and case manager to achieve the goals/ action steps, as well as when goals/ action steps are completed.

If a client requires financial assistance from a Family Assistance and Resource Group provider in order to achieve their goals, the Housing Stability Plan must clearly describe any conditions related to receiving that financial assistance, such as amount of client contribution, when client contribution is due, and how the client will demonstrate that their contribution has been paid. In this way, the Housing Stability Plan clearly establishes expectations for both case managers and clients for providing/ receiving financial assistance, and provides a written record of that agreement. As noted above, all progress on meeting the goals related to financial assistance must be recorded (i.e. case managers must document on the Housing Stability Plan that a client did or did not pay their portion of a bill on time). This includes all Housing Counseling clients receiving financial assistance, as well as all clients receiving hotel subsidy through Family Assistance and Resource Group.

All Housing Stability Plans must be maintained in the client's file and be made available to Family Assistance and Resource Group Operations Team staff in the event of monitoring, client appeals, or otherwise as requested by the Operations Team.

6.4 Program Exit Plan

All Family Assistance and Resource Group providers are expected to provide all households with sufficient guidance when exiting from services/ programs so that the household has a connection to the resources needed to maintain their housing and support after assistance ends.

All Family Assistance and Resource Group providers are required to develop a Program Exit Plan for every household that is exited from their program or services. The Program Exit Plan is a standard template for use by all Family Assistance and Resource Group providers. The Program Exit Plan includes the household's plan for housing, as well as plans for connections to community supports. Any resource information- such as phone numbers of community supports- must be included on the plan. The Program Exit Plan should mirror goals and accomplishments in the Housing Stability Plan.

A Program Exit Plan is required for any household being terminated from services from any Family Assistance and Resource Group provider.

Case managers will complete the Program Exit Plan prior to a client's exit from a shelter, Rapid Re-Housing program, Transitional Housing Program, or Permanent Supportive Housing Program, and provide the client with a copy of this plan.

Program Exit Plans are not required for clients that leave a program without notice to the case manager, or are unable to be contacted, so long as written documentation of the efforts to contact the client are documented in case notes.

Program Exit Plans will be reviewed during program monitoring visits, client grievance review, or otherwise as requested by the Family Assistance and Resource Group Operations Team.

6.5 Case Notes

All interactions between clients and Family Assistance and Resource Group staff must be documented in CMS with a case note corresponding to the date of the interaction. Case notes must include the mode of communication (in person meeting, email, text, phone call, office visit) and date. It is expected that case management notes are written using proper grammar, spelling, etc., and that they convey the professionalism with which the services are provided.

The case note must include a summary of the discussion and any information provided by the case manager to the client. This summary is to be written in objective language only and should not contain any language that reflects the writer's assessment or subjective opinion.

Case notes documenting case management meetings should provide a full accounting of the work done during the meeting. This includes: case management support provided during the meeting, such as progress on meeting

goals, new action items identified, income and budget work, review of service connections, etc. Any discussion that could be referenced later for an appeal- such as a discussion regarding compliance with the program's agreement policy or progress on meeting goals- must be documented clearly in the case notes. Any time a new Rapid Re-Housing Re-Assessment, SPDAT, or budget is completed, the case note must indicate this and include a summary of the result.
It is the expectation that case notes are submitted into CMS in a timely manner, reflecting current status and real-time. Case notes are to be entered no later than 1 week from the encounter, outreach, phone call, or other contact made with the client. All case notes for each program are to be entered into CMS by end of business day Monday for the week prior. Case notes must reflect all contact or attempted contact made (which includes voicemails left, calls put in, texts exchanged). *If a case note is not entered, it did not happen!*
For privacy issues, see policy on Case Notes in the FAC Data Systems Policies and Procedures.

6.6 Case Note Sharing

Case note features are available within CMS HS for use by any participating agency, though some programs are required to keep case notes in order to better facilitate service coordination: 1) Referral notes are used by the Call Center to more fully describe housing crisis situations at the point of referral, 2) Housing Resource Center staff are required to maintain a publically-viewable case note on client's progress towards moving into permanent housing, and 3) Shelters are strongly encouraged to adopt similar protocols internally to better coordinate with other housing programs. These policies are described in the Housing Resource Center Policies and Procedures Manual and in each shelter's internal policy manual.
Participating agencies and case workers may wish to maintain internal case notes within CMS HS as well. Notes that are intended to be shared with other agencies for the purposes of service coordination must be maintained as publically viewable, including but not limited to notes on referrals and on housing plans. Case notes that are intended as internal notes should be marked as private at the discretion of the case worker. Persons with access to CMS HS are prohibited from viewing case notes recorded for clients other than those on their case load or referred for services, in accordance with the Policy on Ethical Data Use.

6.7 Data Entry & Compliance

Providers who enter program data into CMS are required to perform monthly data quality monitoring. Once a month, program supervisors must:
1. Run a *Program Roster Report* and compare enrolled households to the program's active clients served, ensuring that household family members are properly linked in CMS and that all individuals have been properly enrolled or closed out of a program or service.
2. Run an *HMIS Data Quality Report* and review any identified fields where a service provider entered "Client Doesn't Know", "Client Refused", "Data Not Collected", or the data field was left blank. To the best of their ability, these fields must be completely filled out to reflect accurate and proper information. **IMPORTANT**: **Providers must only report what is truthful. Sometimes data quality will not be 0%. If information is truly not available, then CMS should reflect that.**
3. For programs that provide security deposit, rental, or utility assistance, run a *Client List Report* and ensure the correct funding source (both type & amount) is listed.

7. Rapid Re-Housing Policies

7.1 Rapid Re-Housing Eligibility for New Clients

In order to be eligible as a new client for Rapid Re-Housing, households must be able to provide documentation of the following:

- 1. Homeless Status: households must meet one of the following definition of homeless status, and Rapid Re-Housing providers must obtain the Recordkeeping Requirements listed below and maintain in the client's file:
    - *Literally Homeless:* Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: Has a primary nighttime residence that is a public or private place not meant for human habitation;
- Is living in a 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 and local government programs); or
- Is exiting an institution where (s)he has 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
    - Recordkeeping requirements: Written (printed HMIS record or standardized letter (Form 3.2)) observation by the street outreach worker; or
- Written (printed HMIS record or standardized letter (Form 3.2)) referral by another housing or service provider, or
- Written certification by the individual or head of household seeking assistance that (s)he was living in the streets or in shelter;
- For individuals exiting an institution- one of the forms of evidence above documenting that the individual was living on the street or in an emergency shelter immediately prior to entering the institution, and that the individual was living in the institution for less than 90 days, and (1) Discharge paperwork signed by the Institution Social Worker, and

(2) Written record of housing plan created by the Institution Social Worker and Family Assistance and Resource Group confirming Family Assistance and Resource Group assistance, and
(3) Approval from the Family Assistance and Resource Group Program Manager (email or referral record)

2. LinnCounty Residency, per the Policy on County Residency.

There is no income limit for households at intake into Rapid Re-Housing; however, income documentation must be collected.
Once a household has been determined eligible for assistance, Housing Stability Coaches must confirm this determination by completing the Certification of Eligibility for Rapid Re-Housing Assistance Form and attaching all required supporting documentation:
• Documentation of homeless status;
• Documentation of LinnCounty residency;
• Documentation of income or Self-Declaration of Income if documentation is not available or the household does not have any income;
• Program agreements and forms: o Rapid Re-Housing Program Agreement
o Family Assistance and Resource Group Data Systems Release of Information
o Monthly budget
o SPDAT
o Housing Stability Plan

By signing the Certification of Eligibility form, the Housing Stability Coach and Supervisor attest that the household meets all eligibility requirements for the program.

All eligibility documentation must be maintained in the client's file.

7.2 Rapid Re-Housing Intake

Intake into Rapid Re-Housing is considered the period during which an applicant has been contacted by a Housing Stability Coach to schedule their first appointment for Rapid Re-Housing, up until the applicant signs the Rapid Re-Housing Program Agreement, or until the Housing Stability Coach determines the applicant is ineligible for the Rapid Re-Housing Program. No financial assistance may be provided to clients from the Rapid Re-Housing Program during intake.

To the extent feasible, the Housing Stability Coach will schedule all intake appointments with an applicant for Rapid Re-Housing jointly with all case workers currently working with the applicant, so that a client's full case history and any current housing plans can be shared openly between case workers. Typically this will include the emergency shelter case worker, and will often also include the Critical Time Intervention worker or other mobile mental health support workers.

The intake appointment(s) with the applicant will be scheduled at a convenient location for the applicant; this will generally be at the emergency shelter, hotel, or a public facility near where they reside.

7.3 Recording Ineligibility or Denial from Rapid Re-Housing

During intake, a Housing Resource Center case manager may determine that a client is ineligible for the Rapid Re-Housing program. If the whereabouts of the client are known, the Housing Resource Center case manager must provide a written determination of ineligibility to the applicant. If the whereabouts of the applicant are unknown, the Housing Resource Center case manager will record a Case Note in CMS to document the determination. All applicants denied entry into the Rapid Re-Housing program may appeal this determination by writing to the Family Assistance and Resource Group Program Manager within 10 business days of receiving the denial.

7.4 Rapid Re-Housing Enrollment

An applicant for Rapid Re-Housing is considered enrolled into the Rapid Re-Housing program when they sign the Rapid Re-Housing Program Agreement. An applicant for Rapid Re-Housing that refuses to sign the Program Agreement will not be enrolled into Rapid Re-Housing. Refusal to sign the Program Agreement must be documented in case notes in CMS.

7.5 Rapid Re-Housing Introductory Period

The primary goal of Family Assistance and Resource Group Rapid Re-Housing is to help clients move to permanent housing as quickly as possible. In order to ensure that all clients are actively working to gain housing through this program, every enrollment into the program begins with an Introductory Period, in which clients must actively participate in locating housing to the extent that is reasonable based on their skills and abilities. This Introductory Period is not meant to place undue expectations on high-need clients from obtaining housing- clients may only be evaluated on whether they are meeting expectations that are consistent with their abilities. All households enrolled into the Rapid Re-Housing Program will be subject to an initial 60-day Introductory Period, in which time they will need to meet the following criteria in order to remain eligible for continued assistance through the Rapid Re-Housing Program:

- Actively participate in locating a unit, consistent with their abilities to do so, as demonstrated by follow-through on the action steps identified in the Housing Stability Plan developed during their intake appointment.
- Maintain homeless status eligibility for the program. Households living in non-homeless settings (e.g. doubling up) for longer than 2 days during this timeframe are considered to have lost their eligibility for the program.
- Maintain consistent contact with their Housing Stability Coach and Locator, defined during this time period as at least once per week.

• Provide documentation and/or payment as requested by their Housing Resource Center workers in order to move into housing.
• Attend unit inspections/walk-throughs and lease-signings as requested by their Housing Locator.
• Accept at least one out of three unit options provided, so long as all options meet the client's location requirements for work or support services, budget, and accessibility needs as outlined in their Housing Search Planner.
• Be approved for a unit.

The Introductory Period ends 60 days after the date of program enrollment, or on the day that the client moves into permanent housing, whichever is sooner.
The Introductory Period may be extended at 60 days, with Supervisor approval, if the client has not been approved for a unit and if the client has high needs, significant barriers to housing, or is otherwise actively engaged in the housing location process but unable to find/ be approved for units through no fault of their own. In this case, the Housing Stability Coach and Locator will create a new Housing Stability Plan and Housing Search Planner with the client outlining the new terms of the Introductory Period and establish the timeframe for the extension, as is reasonable based on the client's situation.
Households that do not meet the requirements of the Introductory Period at 60 days will be terminated from the Rapid Re-Housing program, consistent with the policies outlined in the Rapid Re-Housing Program Agreement and the Rapid Re-Housing Exit/ Termination policies. If terminated during the Introductory Period, households are not eligible to be re-enrolled into the Rapid Re-Housing Program for 60 days from the date of their termination.

7.6 Rapid Re-Housing Program and Emergency Shelter Communication

In order to provide consistent, coordinated services to clients, it is imperative that all program staff from both Housing Resource Centers and Emergency Shelters maintain constant communication directly with each other regarding a shared client's services. Direct communication refers to email or phone messages between case workers; case workers should not expect or ask clients to relay messages between case workers.
Direct communication between shelter staff and Housing Resource Center staff is expected to occur when:
• Intake appointments for Rapid Re-Housing are scheduled
• Housing Stability Plans are created and signed
• Periodically during housing location to update on progress achieved in locating housing
• Inspections are approved
• Lease signings are scheduled
• Move-in dates are scheduled
• A client's enrollment in the Rapid Re-Housing program is in jeopardy or the client is otherwise not fulfilling expectations set forth in the Rapid Re-Housing Program Agreement or Housing Stability Plan
• A client's enrollment in the shelter is in jeopardy, the client does not sleep in shelter for 2 nights, or the client moves out of the shelter
• Other changes or situations arise that would affect the client's ability to obtain housing

7.7 Rapid Re-Housing Program and Communication with Community Partners

In order to provide consistent, coordinated services to clients, it is imperative that program staff from Housing Resource Centers maintain constant communication directly with case management services that are also supporting the household. Communication with services such as Critical Time Intervention (CTI), Office of Jackson Street Youth, Recovery Coaching, and other community partners is imperative for integrated goal planning and housing success. Direct communication refers to email or phone messages between case workers; case workers should not expect or ask clients to relay messages between case workers. Housing Resource Center staff are to answer emails and phone calls from community partner case workers within 1 business day.

Direct communication is expected to occur when:
• Intake appointments for Rapid Re-Housing are scheduled
• Housing Stability Plans are created and signed
• Periodically during housing location to update on progress achieved in locating housing
• Inspections are approved
• Lease signings are scheduled
• Move-in dates are scheduled

• A client's enrollment in the Rapid Re-Housing program is in jeopardy or the client is otherwise not fulfilling expectations set forth in the Rapid Re-Housing Program Agreement or Housing Stability Plan
• A client receives a strike with the Rapid Re-Housing program
• A client experiences a crisis or additional support in order to maintain housing is needed
• A household is being discharged from the Rapid Re-Housing program

7.8 Housing Stability Planning in Rapid Re-Housing

All Housing Stability Coaches must complete a Housing Stability Plan with every client at least once every three months, or more frequently as needed. The Housing Stability Plan must clearly outline the action steps of both the Coach and the client, the due dates for each task, and the required documentation or follow-up for each task. Every Housing Stability Plan must be signed by the Coach and the client. A copy of every Housing Stability Plan must be given to the client and a copy must be retained in the clients' file. While the client is in shelter, the Housing Stability Plan must be uploaded to the client's profile in CMS and shared with the client's shelter case worker.

Housing Stability Coaches should use the results of the SPDAT, the client's existing housing or case plan at the shelter, and any other relevant information to develop Housing Stability Plans. It is expected that each Housing Stability Plan will identify multiple areas/ domains for action (such as Housing, Health, Public Benefits). The number of tasks included on the Housing Stability Plan should be consistent with the client's abilities.

Housing Stability Coaches must document the results of each Housing Stability Plan, including client's follow-through with tasks and completion of tasks by the assigned deadlines. The results of the Housing Stability Plan must be shared with the client, so the client is able to see their own progress on the plan, and is aware of any missed items or tasks. All follow-up documentation must be retained in the client's file.

In instances where a client is discharged from Rapid Re-Housing as a result of lack of follow-through on goals, the appropriate Housing Stability Plan(s) must be referenced as back-up documentation. A discharge for lack of follow-through on goal planning that does not include appropriate Housing Stability Plan documentation will be overturned.

7.9 Housing Location Assistance

During the initial meetings with the Rapid Re-Housing program staff, the Housing Stability Coach and Housing Locator will help the client to outline the action steps, expectations, and parameters for locating and moving into permanent housing. This plan must include:
• Identification of the client's preferred communities/ neighborhoods, including those near the household's school, work, relatives/ support network, doctors, etc.
• The target rent and utility amount, based on the client's current and projected income and the Fair Market Rate/ Rent Reasonableness standards
• Resources to find units (online, print, landlord names, etc.)
• Expectations regarding client contact with the Housing Locator- frequency, method, and contact information.
• Expectations for finding units and contacting landlords. These should be developed based on the client's abilities, rental history, presence of barriers to housing, and in consultation with shelter staff.

Housing Locators are expected to provide more assistance in locating units to clients with higher needs/ barriers (such as poor rental history or no experience calling landlords) than those with fewer needs.

Housing Locators are expected to assist clients in finding units through utilization of their own networks and relationships. Housing Locators must be in direct communication with the client's shelter case worker if problems arise regarding the client's follow-through with the action steps on the Housing Stability Plan. If it is determined that the client needs additional assistance in housing location, the Housing Locator must create a new Housing Stability Plan that better meets the needs of the client in obtaining housing.

7.10 Rapid Re-Housing Lease and Tenancy Education

The Housing Locator is responsible for ensuring that the client understands the terms of their lease agreement. To do so, the Housing Locator must review all provisions of the lease with the client.
The Housing Locator is responsible for helping clients to abide by the terms of lease and exhibit good tenancy skills, as appropriate for their abilities. This may include additional sessions in which the Housing Locator provide additional educational materials or guidance to the client about tenancy issues, especially following any incident that violates a lease agreement or could lead to poor landlord-tenant relationships.

7.11 Rapid Re-Housing Case Management

A core component of Rapid Re-Housing is providing regular case management support to clients to help them obtain and maintain stable housing.
Housing Stability Coaches are required to meet in-person with enrolled clients at least once per month, though Coaches are expected to meet more frequently with clients with identified high needs, barriers to housing stability, or difficulty meeting Housing Stability Plan goals as described in the Program Guidance on Progressive Engagement in Rapid Re-Housing.
Housing Stability Coaches are required to conduct a home visit to clients within 5 days of the client moving into a new unit. Once a client has been housed, Housing Stability Coaches are required to hold case management meetings in the client's home at least once per three-month period or as often as indicated by client needs.
During case management meetings, Housing Stability Coaches are expected to review and record the client's progress on meeting goals identified in the Housing Stability Plan, review the client's budget and payment of bills, and to connect to supports or other services that will assist the client in maintaining their housing. Case management is not a one-size-fits-all approach, and so certain clients may require more or less work in certain areas than others. However, all case management meetings should cover the basics of progress towards attaining income to meet basic needs, and maintaining housing stability.
The level of case management support will vary based on the client's needs, and it is the responsibility of the Housing Stability Coach and their Supervisor to determine the appropriate level of case management support for each client. In general, Housing Stability Coaches are expected to provide more intensive and frequent case management support to clients with high acuity/ needs, and less intensive case management support to clients with fewer support needs. Housing Stability Coaches are expected to increase or decrease the frequency and intensity of case management supports to clients as they work with clients and are able to better assess their acuity.
Rapid Re-Housing case management also includes regular check-ins and follow-up on activities in between in-person meetings.

7.12 Connection to Supportive Services

It is expected that most Rapid Re-Housing clients will need to connect to other community or professional supports in order to maintain their housing long-term. These supports include, but are not limited to, mental

health case management/ services, medical services, subsidized childcare, public benefits, employment/ career counseling, legal services, and budgeting/ credit counseling.
Housing Stability Coaches are responsible for appropriately identifying the additional areas in which the household needs more support. The primary tools for identifying these areas are the SPDAT and budget, though Housing Stability Coaches may use other information or their own assessment to inform this as well.
While Housing Stability Coaches are not expected to provide case management services in other identified support areas, Housing Stability Coaches are responsible for ensuring that clients are connecting to appropriate services. This includes:
• Including all support connections as goals and action steps on the Housing Stability Plan,
• Assisting with or making referrals on behalf of clients to the appropriate service,
• Ensuring that the client has completed the necessary intake paperwork for the service,
• Following up on the status of the application for service,
• Advocating for the client to receive the service by reporting connection issues to their Supervisor.

Once a client has been connected to the service(s) needed, the Housing Stability Coach is responsible for ensuring that the client is maintaining an active role in this service by:
• Identifying attendance/ participation in the service on the Housing Stability Plan,
• Maintaining regular communication with the service case worker/ contact,
• Maintaining an active knowledge of the case work or activities being completed by the client through this service,
• Reviewing meeting attendance/ participation with the client,
• Adjusting the Housing Stability Plan and/or notifying the Supervisor if services provided are not meeting the client's needs.

7.13 Rapid Re-Housing Re-Certification

All households enrolled in Rapid Re-Housing must be re-certified for eligibility every 3 months from the date they have been moved into permanent housing in order to continue receiving services from the program. The 3 Month Re-Certification confirms:
1. Income Eligibility. Household's income is at or below 30% of the Area Median Income.
2. Need for Services and Supports: All households must also demonstrate continued need for the case management services and/or financial supports provided by the program, and the lack of the other resources (family networks or community services) to meet these needs.

Households that meet the Re-Certification requirements will be certified to receive another 3 months of assistance. A household may be re-certified to receive 3 more months of case management without the financial support, if they are still in need of connection to services.
Households that do not meet either of the criteria above at the 3-Month Re-Certification period will be exited off the Rapid Re-Housing program. If a household is still under 30% of the Area Median Income but is able to afford rent and basic necessities through their own resources, the household will be exited off the Rapid Re-Housing program.
The Re-Certification must include documentation to support the household's eligibility for services:
• Current income documentation or Self-Declaration of Income Form;
• Monthly budget;
• Updated Housing Stability Plan;
• Updated SPDAT;
• Updated Rental Agreement;
• All case notes from the last 3 months.

By signing the Re-Certification form, the Housing Stability Coach and Supervisor attest that the household have been re-assessed for all eligibility requirements and have met all eligibility requirements.

7.14 Client Contribution to Housing Costs

Because Rapid Re-Housing assistance is time-limited, households are expected to contribute financially to their housing costs. Housing Stability Coaches and Housing Locators are expected to help clients identify an appropriate amount to contribute to security deposit/ move in costs, ongoing rent and utilities, and other costs (such as basic household goods) based on the household's ability to pay.

Households with income: Households with income are expected to pay 30% of their income towards their housing costs (rent and utilities) during their first three months in the program. It is encouraged, but not required, for all households with income to contribute to their move-in costs as well. Housing Stability Coaches may determine the most appropriate method for clients to contribute this amount; however, it is encouraged that clients begin paying a portion of each bill they are responsible for (rent and utility) so that they begin developing the habit of paying these bills on time and to the appropriate vendor.

During their next phases of their time in the program (4- 24 months), households with income are expected to increase their contribution to their housing costs from at least 30% to up to 100% by the time they are exited from the program. In order to determine the increase in housing costs, Housing Stability Coaches should work with clients to develop a housing budget and rent increase plan that balances the client's ability to pay with the time available in the program. An updated Rental Agreement for Re-Certification letter must be signed by the client and sent to the landlord to document the plan for rental assistance.

Households without income: Households without income are expected to contribute what they can towards their housing costs (rent and utilities). This may include bartering, recycling returns, or other safe forms of generating income from non-traditional sources. In these instances, it is expected that financial goals in the Housing Stability Plan be clear, outlining the client's expected efforts to increase his or her income based upon their ability. It is the responsibility of the Housing Stability Coach to monitor these financial goals and support the client in these goals by making appropriate referrals. The Housing Resource Center will continue to support the client as long as they make progress in their goals outlined in the Housing Stability Plan, with the household continuing to contribute what they can towards their housing costs. Once household income starts to increase, it will be expected that the household increase their contribution to their housing costs from at least 30% to up to 100% by the time they are exited from the program.

7.15 Rapid Re-Housing Rental Agreement

Family Assistance and Resource Group Rapid Re-Housing guarantees payment of the Housing Resource Center's portion of housing costs only, as documented in the Rental Agreement. The portion of housing costs assigned to the client/ tenant are not guaranteed to be paid to the landlord by the Housing Resource Center.

In certain cases, the Housing Stability Coach and their Supervisor may approve payment of a client's portion of rent to the landlord. These cases include:

- Sudden loss of income source
- Financial crisis

In either case, the incident and inability to pay must be clearly documented. In cases where income was diverted to resolve another crisis, the client must be able to document how funds were spent (i.e. through receipt of payment).

Housing Resource Center Supervisors will provide final approval for payment of client's portion of rent due. Because clients are expected to provide proof of payment of rent within 5 days of the rent due date, Housing Resource Center staff are expected to identify nonpayment of rent within the first month of nonpayment. In cases where the client is expected to be unable to pay their portion of rent for the remainder of the Rental

Agreement period, the Housing Stability Coach, Locator, and Supervisor should adjust the Rental Agreement so that the client is not in violation of their agreement. (For example: a client who suddenly loses their income source one month would be unable to pay the following two months, and so the Rental Agreement should be re-calculated to address this).

In general, payment of more than one month of client's rent portion at once (i.e. to prevent an eviction after multiple months of non-payment) is not allowable, as HRC staff should have identified non-payment issues within 5 days. In the case a Supervisor feels payment of multiple months of a client's portion is necessary, this request must be approved by the Family Assistance and Resource Group Program Manager.

7.16 Rapid Re-Housing Client Exit/ Termination

Rapid Re-Housing clients may be exited or terminated from the program for the following reasons:
1. Lack of eligibility or need for services. a. During the RRH Introductory Period, in which a client is looking for a unit, they may lose eligibility if they are no longer literally homeless. In these instances, the client will be terminated from the program immediately. There is no timeframe following this discharge during which a client will be ineligible for re-enrollment.
b. Once housed, a client may no longer meet the income eligibility (below 30% AMI) or may no longer have a demonstrated need for the services provided by the program, according to the Program Guidance and Policy on Rapid Re-Housing Re-Certification. In these instances, the client will be exited at the close of the current 3 month period. These clients successfully exited off of the Rapid Re-Housing Program are eligible for re-enrollment should they recidivate to literal homelessness in the future.

2. Documented lack of compliance with the Program Agreement as outlined in the Rapid Re-Housing Program Agreement or Client Rights and Responsibilities. In order for a client to be terminated due to non-compliance with the Program Agreement (including no contact/ no show at meetings), the Housing Stability Coach must: a. Have complete, accurate case note documentation and/or additional documentation as appropriate to document lack of compliance with the Program Agreement and/or Client Rights and Responsibilities.
b. Have provided 2 separate letters to client, and confirmed receipt of the letters to the client, informing the client that they have received a first and second "strike".
c. Have met with the client and their Supervisor to discuss the reason for each "Strike," and provided written documentation to the client as to what they need to do going forward to maintain their good standing in the program, following each meeting.

Upon the third documented strike, clients will be exited from the program immediately.
Clients terminated from Rapid Re-Housing due to non-compliance with the Program Agreement or Client Rights and Responsibilities are not eligible for re-enrollment for a period of 60 days from the program exit date. **Note that verbal/ physical threats are an exception to this three-incident policy and is explained in point #4 below.*
3. Client received the maximum amount of financial assistance available, 24 months. All case management and financial assistance ends immediately at 24 months. Clients receiving the maximum assistance allowable are not eligible for re-enrollment for a period of three years from their program exit date.
4. Verbal or physical assault. Clients verbally threatening to cause imminent physical harm to a Family Assistance and Resource Group staff person, or any client that physically harms a staff person, will be immediately discharged from the program following Family Assistance and Resource Group Program Manager approval. Clients terminated from Rapid Re-Housing due to verbal/ physical assault are not eligible for re-enrollment for a period of 60 days from the program exit date. **Note that threat of verbal/ physical assault is an exception to the Program Agreement exit policy as referenced in point #2 above.*

5. Client is living in other housing. Re-housed clients that begin living in housing other than the arranged unit (such as with family or friends) will be discharged immediately from the program. In this case, clients will not be eligible for re-enrollment in Rapid Re-Housing for a period of 60 days following the date of their discharge.
6. Client is committed to a public institution (jail, detox, etc.) voluntarily or involuntarily for a time period greater than 90 days. Once it has been confirmed by a medical or social service professional that the client will be remaining in a public institution for more than 90 days, the client will be discharged from the program immediately. These clients are eligible for re-enrollment should they recidivate to literal homelessness in the future.

In all cases of clients exiting the program (voluntarily or involuntarily), the Housing Stability Coach must provide written communication to the both the client and the landlord. Housing Stability Coaches must also inform any other Family Assistance and Resource Group partner case workers with whom the client is currently working. All clients must be provided a Housing Stability Plan for Exit and the Grievance Procedures.

7.17 Rapid Re-Housing Clients Committed to Public Institutions

Units for clients committed to public institutions for a period of 90 days or less will be held for the client, so long as the client (or their case worker at the institution) maintains regular communication with the Housing Resource Center, defined as at least once every 30 days. If a client and/or their case worker do not maintain regular contact with the Housing Resource Center during the time in the institution, the Housing Stability Coach may discharge the client from the Rapid Re-Housing program, with Supervisor approval. In this instance, any current landlord Rental Agreement will be honored but case management services will end immediately.
Clients committed to public institutions for longer than 90 days will be discharged from the program immediately.

7.18 Rapid Re-Housing Program Agreement and Client Rights and Responsibilities

The Rapid Re-Housing Program Agreement outlines the expectations for both clients and case managers. The Housing Stability Coach must read and explain every provision in the Program Agreement and Client Rights and Responsibilities to the client during the intake process prior to enrollment into the program. Rapid Re-Housing clients must agree to and comply with the Rapid Re-Housing Program Agreement in order to be or remain eligible for assistance.
Clients must be provided written notice if their standing in the program is in jeopardy. Any time a client is provided notice that their standing in the program is in jeopardy, they must be provided an opportunity to meet in-person with their Coach and Coach's Supervisor to discuss the issues. In all instances, clients must be provided clear, written guidance on how to improve their standing in program.
Clients receiving more than two notices (for two separate incidents/ issues) may be terminated from the Rapid Re-Housing program, so long as the Housing Stability Coach has done the following:
1. Ensured that the client understands the terms and expectations of the Program Agreement and Client Rights and Responsibilities. Efforts should be made to ensure that clients with high needs, such as those with disabilities, limited English proficiency, or otherwise, are held to fair and reasonable standards based on their abilities.
2. Collected all documentation necessary to clearly demonstrate lack of compliance with the Program Agreement. This includes: documentation of missed meetings through case notes, correspondence from the landlord, correspondence from partner organizations of missed meetings, documentation on the Housing Stability Plan(s) of lack of follow through on action steps, or similar.
3. Provided written communication to the client notifying them that their standing in the program is in jeopardy as a result of not meeting Program Agreement expectations. Housing Stability Coaches must be able to provide proof that they ensured the client received all notices, offered the opportunity to meet with themselves and their Supervisor, and provided guidance on how to comply with the Program Agreement.
4. Received approval from their Supervisor to terminate the case.

When appropriate and reasonable, Housing Stability Coaches are encouraged to meet with clients for a final in-person meeting in order to discuss the reason for their termination and to develop a Housing Stability Plan for Exit.
In all cases, the Housing Stability Coach must provide/ send the client written documentation explaining the client's reason for termination, termination date, and remaining financial assistance. The Housing Stability Coach must also provide a written Housing Stability Plan for Exit. Finally, the Housing Stability Coach must provide a copy of the Grievance Procedures.
The Housing Stability Coach must send a letter to the landlord informing him/her of the last date of financial assistance.
The Housing Stability Coach must also contact any other current Family Assistance and Resource Group partner agency case workers with whom the client is current working to inform them of the client's exit date from the program.

7.19 Grievances with Rapid Re-Housing Termination

Any household exited from the Family Assistance and Resource Group Rapid Re-Housing program may appeal this decision by writing to the Family Assistance and Resource Group Program Manager within 10 business days of receiving notice of their termination from the Rapid Re-Housing program. The Family Assistance and Resource Group Program Manager will review the case and make a final determination on whether to reinstate the client into the Rapid Re-Housing program or to confirm the termination. When reviewing appeal cases, the Family Assistance and Resource Group Program Manager will assess whether the reason for termination is consistent with termination policies and procedures, and whether the documentation supporting the termination meets the standards outlined in the Rapid Re-Housing Program Agreement policy. The Family Assistance and Resource Group Program Manager will inform the client and the Housing Resource Center of the decision within 10 business days of receiving the household's written appeal.

7.20 Eligible Uses For Rapid Re-Housing Funding

FAC Rapid Re-Housing funding may be used to provide the following for clients enrolled in the Rapid Re-Housing program. HRC Supervisors must also reference the Invoicing and Eligible Costs Checklist Form (Form 5.36) to ensure invoicing compliance.:

Rapid Re-Housing Direct Client Subsidies:

• Hotel assistance for persons who are literally homeless (as eligible under the policy on Emergency Hotel Assistance) for a period of up to 30 days while the person is looking for permanent housing. (Note that hotel stays exceeding 30 days must be approved by the Family Assistance and Resource Group Program Manager and reimbursed through the Family Assistance and Resource Group Initiative Fund).
• Move-in costs o Rental Application Fees (When charged by owner to all applicants)
o Security Deposits (Equal to no more than 1 month's rent)
o First Month's & Last Month's Rent
o Utility Deposits (When required by utility company for all customers)
o Moving Costs (Cost of truck rental, moving company, up to 3 months of storage)
• Rental/ utility assistance o Short-term rental assistance (0-3 months)
o Medium-term rental assistance (4-24 months)
o Utility Payments (Up to 24 months of payments per service, including one-time payment of up to 6 months of arrears per service)

Additional Requirements

• Rental assistance cannot be provided to a program participant that is receiving Tenant-Based Rental Assistance or living in a unit receiving Project-Based Rental Assistance or operating assistance through other public sources.
• Utility assistance should only be provided when other utility assistance programs are not available

7.21 Family Assistance and Resource Group Initiative Fund Eligible Use Policy

The Family Assistance and Resource Group public-private partnership maintains a Family Assistance and Resource Group Initiative Fund at the LinnCounty Foundation, Inc. for philanthropic grants and donations contributed to the cause of ending and preventing homelessness in LinnCounty. Resources permitting, the Family Assistance and Resource Group Initiative Fund provides flexible funding for Family Assistance and Resource Group Housing Stability Coaches, Housing Locators and Housing Counselors to quickly and effectively help families and individuals exit from homelessness to permanent housing with stability. Using a progressive engagement approach, Family Assistance and Resource Group service providers offer only those resources necessary to help clients succeed and only after all public and community resources have been exhausted.

Family Assistance and Resource Group providers should make every reasonable effort to procure items at low prices to conserve the limited private dollars available through the generosity of grantmakers and individual donors to the Fund.

Family Assistance and Resource Group Initiative Fund eligible uses include the following:

- **Consumer Assistance**
  - o Birth certificate or ID replacement costs
  - o Car repair/car insurance
  - o Job training program costs (fees, uniforms and equipment)
  - o Child care/day care services
  - o Extermination (if not paid for by public dollars or lease agreement)
  - o Food gift cards
  - o GED and College Entrance testing costs
  - o Motel/hotel stay longer than 30 days (Requires FAC Program Manager approval)
  - o Renters insurance
  - o School uniforms and books
  - o Transportation costs for housing, health, child care, employment and job training appointments (bus tokens, train passes, taxi rides, etc.)
  - o Bedroom Items (Beds, bedbug mattress protectors, pillows, blankets, sheets, etc.)
  - o Kitchen Items (Kitchen/cooking items, food staples, etc.)
  - o Living Room Items (Furniture, fans, AC Units – medical need only, etc.)
  - o Home Maintenance Items (Vacuums, cleaning supplies, etc.)
  - o Personal Care Items (Towels, bathroom items, personal hygiene, etc.)
- **Landlord Engagement (for landlord/property manager recruitment and retention)**
  - o Landlord risk mitigation for damage beyond security deposit
  - o Landlord signing bonuses for leasing to Family Assistance and Resource Group clients
  - o Landlord engagement events

See the Family Assistance and Resource Group Landlord Engagement Policies for limits and restrictions.

7.22 Lease Violations by a Family Assistance and Resource Group Rapid Re-Housing Client Policy

In the instances when a Rapid Re-Housing tenant is violating the terms of their lease, specifically when they are allowing non-leased residents to reside in the apartment being subsidized by a Rapid Re-Housing subsidy, the Housing Resource Center must review specific provisions in the lease regarding the allowance of subleasing or guests. There must be provisions in the lease against subletting or long-term guests in order for the landlord to evict a tenant. Neither the landlord nor the HRC have the ability to directly evict a subtenant or guest. Furthermore, Family Assistance and Resource Group staff may not discuss tenancy directly with the subtenant or guest. The landlord is responsible for properly evicting a tenant for violation of the lease through legal measures, if they choose to do so. Family Assistance and Resource Group may only take programmatic action against the tenant per FAC policies if it is determined that the tenant is in violation of their lease.

8. Housing Location and Landlord Engagement Policies

8.1 Family Assistance and Resource Group Landlord Engagement Fund Guidelines Policy

Family Assistance and Resource Group Housing Locators work with landlords and property managers to match Rapid Re-Housing clients with appropriate rental units as quickly as possible. Family Assistance and Resource Group Housing Resource Centers can access philanthropic dollars from the Family Assistance and Resource Group Initiative Fund as available to incentivize landlords and property managers to lease units to Family Assistance and Resource Group clients. Family Assistance and Resource Group Housing Resource Centers must follow the policy outlined here *while also abiding by Family Assistance and Resource Group Initiative Fund budgets provided by the Office of Housing and Community Development.*

Housing Locators should approach landlords and property managers with the Family Assistance and Resource Group Landlord Engagement Agreement (Form 5.14), once it has been agreed upon that a landlord/property manager will be receiving an incentive payment or mitigation payment to house a Family Assistance and Resource Group client. Once a landlord or property manager has signed the agreement, Housing Locators should immediately begin the tenant referral process. Payments should be issued to a landlord or property manager in check form only after actual leases have been signed.

I. GRATITUDE PAYMENTS

Landlord and property managers who agree to house a Family Assistance and Resource Group client are eligible for an incentive payment upon a client moving into the unit. The maximum payment for an incentive given to house one household shall be one-month's contract rent or $250, whichever is the lower amount. The maximum gratitude payment per landlord or property manager (as defined by their tax ID) is $1000. Housing Locators are required to document landlord information and amount of incentive paid to the landlord on the Family Assistance and Resource Group Landlord Engagement Fund Workbook.

II. MITIGATION PAYMENTS

A. "Easy" Damages: If a Family Assistance and Resource Group tenant damages a unit that is likely to slightly exceed the amount of the Security Deposit, the owner shall be eligible for an Express payment of up to $200 with submission of a written request, a photograph of the damage, and financial documentation to support the request for costs above the security deposit, such as a written quote of the work to be done or receipts of the repairs. The Housing Resource Center Supervisor will approve Express Payments.

B. Maximum Mitigation: If a Family Assistance and Resource Group tenant damages a unit that is likely to exceed the amount of the Security Deposit in excess of $200, the Family Assistance and Resource Group Program Manager will approve Mitigation Payments in excess of "easy damages." The Housing Resource Center Supervisor will provide the FAC Program Manager with the landlord's written request, photographs of the damage, and financial documentation to support the request for costs above the security deposit. Once approved, the HRC will submit payment to the landlord.

C. Apartment Hold: If a landlord agrees to house a Family Assistance and Resource Group client with one of their vacant units, the Housing Resource Center Supervisor may approve a financial "hold" on the unit if it is expected that the process to move in the tenant will cause the vacant unit to remain vacant (for example, during the inspection process). The maximum amount offered to hold a unit will be equal to 1 months' rent.

D. Unpaid Rent Reimbursement: If a Family Assistance and Resource Group Rapid Re-Housing tenant abandons a unit while they are still enrolled in the Rapid Re-Housing Program, the Housing Resource Center Supervisor may approve the payment of unpaid client rent owed to the landlord. The maximum amount of unpaid rent will equal 1 months' rent, or the amount owed by the tenant, whichever is lower.

E. Legal Fees: Family Assistance and Resource Group Housing Resource Center Supervisors may approve the payment of legal fees associated with eviction or other court costs related to lease violations committed by a Family Assistance and Resource Group tenant. The landlord must submit court documents to the Housing Resource Center Supervisors prior to receiving payment.

8.2 Family Assistance and Resource Group Landlord Engagement Policy

Family Assistance and Resource Group Housing Resource Centers should cultivate new and existing landlords and property managers on a regular basis to ensure the availability of appropriate rental units throughout their service area. Units should not be concentrated in one municipality or neighborhood.

To engage landlord and property managers, Housing Resource Centers are expected to:

1. Hold a dedicated landlord event every year. Housing Resource Centers will be reimbursed by the Family Assistance and Resource Group Initiative Fund up to $1,000 for expenses, including space, catering, advertising, collateral materials and thank you gifts. There will be one landlord event per year to engage landlords across the county. HRCs are expected to work together to schedule, plan, and promote this event.
2. Provide landlords and property managers with one telephone number (per Housing Resource Center) for any questions or concerns about the program or a specific client.
3. Be accessible and responsive to landlords and property managers via email, phone, postal mail, etc.; generally defined as responding within two business days.
4. If an issue arises between a Family Assistance and Resource Group tenant, such as unpaid rent or a lease violation, connect Family Assistance and Resource Group landlords, property managers and clients with neutral mediation services through the Department of Housing and Community Development's legal services contracted provider or another nonprofit legal aid provider to avoid a costly and time consuming eviction.

8.3 Family Assistance and Resource Group Landlord Client Information Policy

Family Assistance and Resource Group Housing Resource Centers should help landlords and property managers to understand that families and individuals exiting from homelessness have needs and goals related to achieving housing stability, health and economic security that may change over time. Patience, flexibility and honest communications are critical to helping them succeed.

Housing Locators should communicate the following information to landlords and property managers as frequently as needed and appropriate while following the strictest protocols of client confidentiality required by policy and law:

1. Prior to referring tenants to landlords or property managers, Housing Resource Centers have assessed clients using a standard tool to identify Rapid Re-Housing as the appropriate solution to their housing crisis. Coaches have worked with clients directly to create Housing Stability Plans that include goals for housing, health and economic security related to their specific barriers to housing stability.

2. With the client's permission, Housing Locators will communicate with the landlord or property manager describing in broad terms specific barriers to housing stability identified through the assessment process and steps being taken to address them in the Housing Stability Plan.

3. Every three months that a tenant remains a client of the Family Assistance and Resource Group Rapid Re-Housing program, the Housing Locator will send the landlord or property manager a letter informing them of the client's current progress towards their Housing Stability Plan, their subsidy amount and their projected timeline for program exit.

4. In the event that a client is terminated from the Family Assistance and Resource Group program prematurely, Housing Locators will still be available to landlords and property managers to address their issues or concerns as per the Family Assistance and Resource Group Landlord Engagement Policy.

8.4 Family Assistance and Resource Group Housing Inspection Policy

Family Assistance and Resource Group is committed to providing safe housing that meets basic housing standards for all residents. In order to approve move-in costs for clients, all new units must undergo and pass a Housing Inspection completed through the LinnCounty Public Housing Authority.

A unit that has passed a Housing Inspection through the LinnCounty Public Housing Authority does not need a new inspection completed if a new Family Assistance and Resource Group client moves into that same unit, so long as the new inspection is ordered within a year of the prior inspection date.

All units for which Family Assistance and Resource Group is subsidizing for a period of one year or longer must complete a new Housing Inspection once per year, and maintain a copy of this inspection report.

8.5 Move-In Costs for Family Assistance and Resource Group Clients

Family Assistance and Resource Group Housing Resource Centers may provide First Month, Last Month, and Security Deposit (equal to one month's rent) *only* for move-in costs. While there is no dollar limit on the amount of assistance a client may receive related to move-in costs (unless specified by a grant), case managers are required to follow the principles of progressive engagement to provide the least amount of resources necessary to move the client out of homelessness and into permanent housing. This may include: requiring a client contribution, partnering with other local organizations to combine payments, and helping clients establish payment plans.

Double security deposits are not allowable. Housing Locators may use the Landlord Engagement Fund and/or educate a Landlord regarding mitigation, but are not allowed to approve any payment related to an increased cost in rent or security deposit. Housing Locators, Housing Stability Coaches and Housing Resource Center Supervisors.

8.6 "Protect Your Family from Lead in Your Home" Brochure

Family Assistance and Resource Group is committed to providing safe housing that meets basic housing standards for all residents. Any household receiving Rapid Re-Housing or One-Time Financial Assistance support must receive a copy of the Environmental Protection Agency's brochure "Protect Your Family from Lead in Your Home." A head of household must sign off that they have received this brochure upon move-in. A copy of this receipt must be maintained in the client's file.

8.7 Emergency Transfer for Victims of Domestic Violence, Dating Violence, Sexual Assault, or Stalking

Family Assistance and Resource Group is concerned about the safety of its households, and such concern extends to tenants who are victims of domestic violence, dating violence, sexual assault, or stalking. In accordance with the Violence Against Women Act (VAWA), Family Assistance and Resource Group allows Rapid Re-Housing clients who are victims of domestic violence, dating violence, sexual assault, or stalking to request an emergency transfer from the tenant's current unit to another unit. The ability to request a transfer is available regardless of sex, gender identity, or sexual orientation. The ability of Family Assistance and Resource Group to honor such request for Rapid Re-Housing clients currently receiving assistance, however, may depend upon a preliminary determination that the tenant is or has been a victim of domestic violence, dating violence, sexual assault, or stalking, and on whether Family Assistance and Resource Group has another dwelling unit that is available and is safe to offer the tenant for temporary or more permanent occupancy.

9.7 Documentation Requirements: Existence and Duration of Homeless Episodes

For the purposes of this policy document, and prioritization for PSH beds, the term "homeless" and "homelessness" shall refer only to HUD's definition for Category 1 – Literally Homeless. An explanation of Literally Homeless is provided in the "Definitions" section of this policy document.
A household's history of homelessness can only be used to prioritize the household to the extent that the history is documented.
For all homeless documentation requirements, Family Assistance and Resource Group's order of priority for obtaining documentation is:
1. third-party documentation,
2. intake/referral worker observations, and
3. certification from the person seeking assistance (aka "self-certification").

Records contained in CMS HS, Family Assistance and Resource Group's shared HMIS, are acceptable evidence of third-party documentation and intake/referral worker observations. CMS HS meets the HUD requirement of maintaining an audit trail for this purpose.
Other examples of acceptable third-party documentation or intake/referral worker observation of homelessness include, but are not limited to:
1. Shelter stays – Letters written by shelter staff on the agency's letterhead detailing the name(s) of the individual or family and the beginning and end dates of the shelter stay(s).
2. Places not meant for human habitation – Letters written by Homeless Outreach staff written on the agency's letterhead; Police Reports; etc.

Where third-party evidence or intake/referral worker observation could not be obtained, the intake/referral worker must obtain a certification from the individual or head of household seeking assistance, and must document efforts made to secure more preferred evidence.
In general, self-certification can only be used to document up to three months of homelessness and can only be used for one episode of homelessness. In only rare and the most extreme cases, the Prioritization Committee at its discretion may allow a self-certification for longer periods. The intake/referral worker is required to document the severity of the situation in which the individual or head of household has been living. An example of where this might occur is where an individual has been homeless and living in a place not meant for human habitation in a secluded area and has not had any contact with anyone during that entire period.
A break between homeless episodes is considered at least seven or more consecutive nights not residing in a shelter, safe haven, or place not meant for human habitation.
A single encounter with a homeless service provider on a single day within 1 month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month (e.g., evidence in HMIS of a stay in transitional housing).
For individuals currently residing in an institution, acceptable evidence must include that described in section (a) AND (b) below:
(a) Either : a. Discharge paperwork or a written or oral referral from a social worker, case manager, or other appropriate official of the institution, stating the beginning and end dates of the time residing in the institution that demonstrate the person resided there for less than 90 days. All oral statements must be recorded by the intake worker; or
b. Where the evidence above is not obtainable, a written record of the intake worker's due diligence in attempting to obtain the evidence and a certification by the individual seeking assistance that states that they are exiting or have just exited an institution where they resided for less than 90 days; and

(b) AND: Evidence that the individual was homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entry into the institutional care facility.

9.8 Documentation Requirements: Evidence of a Disabling Condition

All candidates for PSH must provide evidence of a disability. Evidence of this criterion must include one of the following:

(a) Written verification of the disabling condition from a professional licensed by the state to diagnose and treat the condition. Acceptable formats include (but are not limited to) the following: a. The PA Department of Public Welfare Employability Assessment form. If the form indicates temporary disability, follow-up documentation may be needed.

b. Family Assistance and Resource Group PSH Certification of Qualifying Condition form.

(b) Written verification from the Social Security Administration;

(c) Copies of a disability check (e.g., Social Security Disability Insurance check or Veterans Disability Compensation);

(d) Intake staff (or referral staff) observation that is confirmed by written verification of the condition from a professional licensed by the state to diagnose and treat the condition that is confirmed no later than 45 days of the application for assistance and accompanied with one of the types of evidence above; or

(e) Other documentation approved by HUD.

Please note the following:

(a) Any documentation that includes medical information should not be uploaded to the person's CMS file. Otherwise, in general, all referral "paperwork" should be uploaded.

(b) Some programs may have agreed to serve specific sub-populations as part of their grant agreements (for example: Serious Mental Illness, HIV/AIDS, etc.). Providing documentation that indicates the nature of the disabling condition (ex: a diagnosis) may increase PSH options for the person.

9.11 PSH Policy Definitions

Break in homelessness - a break is considered at least seven or more consecutive nights not residing in a shelter, safe haven, or place not meant for human habitation.

Chronically Homeless

(1) A "homeless individual with a disability,"…who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

(ii) Has been homeless and living as described in paragraph (1)(i) continuously for at least 12 months or on at least four separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering an institutional care facility;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering the facility;

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless. (24 CFR 578)

Developmental Disability – means, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002): (1) A severe, chronic disability of an individual that— (i) is attributable to

a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: (A) self-care; (B) receptive and expressive language; (C) learning; (D) mobility; (E) self-direction; (F) capacity for independent living; (G) economic self-sufficiency. (v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (2) An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in paragraphs (1)(i)
through (v) of the definition of ''developmental disability'' in this section if the individual, without services and supports, has a high probability of meeting these criteria later in life. (24 CFR 578.3)

Disabling Condition – (1) A condition that: (i) is expected to be long-continuing or of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by the provision of more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or (2) A development disability, as defined at 42 U.S.C. 15002; or (3) The disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5.)

Federal Definition of Serious Mental Illness - Adults with a serious mental illness are persons:

1. age 18 and over,
2. who currently or at any time during the past year,
3. have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III-R,
4. that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

These disorders include any mental disorders (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-III-R "V" codes, substance use disorders, and developmental disorders, which are excluded unless they co-occur with other diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity or disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. Adults who would have met functional impairment criteria during the referenced year without benefit of treatment or other support services are considered to have serious mental illnesses.

Literally Homeless (HUD Category 1) – An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

1. Has 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;
2. Is 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
3. 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;

Permanent Supportive Housing projects funded through HUD's Continuum of Care Competition have the following additional requirements

1. Individuals and Families coming from Transition Housing must have originally come from the streets or emergency shelter;
2. One of the heads of household must also have a disability.

Permanent Supportive Housing – means community-based housing without a designated length of stay, and includes both permanent supportive housing and Rapid Re-Housing. To be permanent housing, the program participant must be the tenant on a lease for a term of at least one year, which is renewable for terms that are a minimum of one month long, and is terminable only for cause. Permanent supportive housing means permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. (24 CFR 578.3)

SPDAT – (Service Prioritization Decision Assistance Tool) the evidence-based assessment utilized by all trained CoC providers in either enacting more detailed determinations of acuity for housing placement and/or ongoing use in case management to ensure housing stabilization. The SPDAT (or "Full SPDAT") has an individual and family tool. Staff must be trained by OrgCode Consulting. The SPDAT can be completed on paper or in HMIS and attached to a client record.

VI-SPDAT – (Vulnerability Index-Service Prioritization Decision Assistance Tool) the evidence-based Prescreen utilized by the Family Assistance and Resource Group Call Center (Centralized Intake) to determine initial acuity (the presence of an issue) and utilized for housing triage prioritization and housing placement.