The Way Home System Practice Standards
Approved by Steering Committee on April 13, 2023
Effective July 1, 2023

Ongoing Updates to the Standards will be tracked here and communicated out to the CoC.

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The Way Home System Practice Standards Guide

This Practice Standards Guide (Guide) provides essential information and guidance to homeless assistance program staff and partners to ensure effective care coordination of persons experience a housing crisis from point of first contact to successful housing placement. The Guide is intended to help program staff better understand The Way Home programmatic components. Practice Standards in this Guide cover the following program types:

- Coordinated Access Assessment
- Outreach
- Diversion/Problem Solving
- Navigation
- Case Management for Rapid Rehousing (RRH) and Permanent Supportive Housing (PSH) projects.

This Guide serves as a reference for TWH grant recipients and CoC Program grant recipients to operate homeless assistance projects and systems with consistency and in adherence to established system norms.

Guiding Principles

These system practice standards establish baseline expectations for the delivery of services across the CoC components of Coordinated Access, Outreach, Diversion, Navigation and Case Management for RRH and PSH projects. The practice standards described within this Guide represent the “how-to” or the application of the service practice in the context of engaging persons experiencing a housing crisis, assessing client-specific needs and goals, and assisting individuals to resolve their housing crisis as rapidly as possible.

The Guiding Principles for this Practice Standards Guide represent the values established by The Way Home CoC as a standard for shaping and directing the work environment for employees administering applicable projects in the CoC.

1. Homelessness is the result of system failures to identify, engage, and adequately support the needs of individuals experiencing extreme poverty.
2. All clients can be housed with the right housing model and service supports when other system barriers are addressed.
3. To the greatest extent practicable, individual choices about where and how to live should be honored.
4. Addressing homelessness requires collaboration from multiple sectors and systems; no single entity can or should have exclusive responsibility.
5. Non-punitive, engagement-focused approaches are more preferrable than enforcement and criminalization. Housing should strategically combine enforcement approaches with housing offers to address broader community health and safety interests.
6. Intensive and persistent client engagement is key to building trust among persons experiencing homelessness.
7. Persons experiencing a housing crisis do best with clear pathways, low-barriers to entry and defined service strategies that result in permanent housing.
8. Permanent Housing placements must be followed by support services to support individuals in successfully maintaining their housing.
9. Program improvements and system refinements must be informed by data-driven decision-making and centered on the experience and direct engagement of persons with lived experience of homelessness.

Applicability

These standards apply to publicly funded entities of The Way Home CoC who are under contract to provide Coordinated Access assessments, Outreach, Diversion, Navigation, and/or Case Management services associated with RRH and/or PSH. These applicable entities could include the following:

- Non-profit homelessness assistance providers
- Publicly funded social services staff
- Faith-based providers of safety net resources
- Coalition for the Homeless of Houston/Harris County

Other CoC system partners contribute to a cohesive and coordinated network of support services to ensure persons experiencing a housing crisis are afforded quick, safe, and housing-focused interventions in support of resolving their housing crisis. These system partners may not be contractually obligated to adhere to practice standards in this Guide but are nonetheless encouraged to support publicly funded CoC partners in their compliance efforts. Other CoC system partners could include the following:

- Law enforcement
- City and County departments administering federal entitlement funds (ESG, CDBG, HOME)
- Universities
- Healthcare providers and hospitals

System standards create clear and specific guidance for homelessness assistance providers to align individual grantee practice with community-established norms for service intensity, duration, quality and integration with other system partners. Although not required to adhere to these standards, some non-funded service partners of The Way Home may choose to adhere to these standards voluntarily.

Roles and Responsibilities

Agencies Providing Services through The Way Home CoC

Agencies, whether direct or subcontracted recipients of the Houston Coalition for the Homeless, City of Houston, or Harris County funds, are responsible for creating and maintaining a non-discriminatory workplace and service provision environment; maintaining an internal quality assurance process; maintaining policies and procedures that govern agency and project operations; ensuring that homeless services programs are meeting the unique needs of marginalized communities; and conducting internal monitoring of Street Outreach projects on their contract compliance and performance.
Responsibilities include:

- Maintain an agreement or MOU between the prime and each subcontracting agency that covers expectations of service deliverables, project outcomes, and data collection.
- Conduct regular check-ups with subcontractors during the contract lifecycle to ensure that contractual expectations are being met.
- Submitting funder required reporting on time
- Indicate full compliance with all federal and state nondiscrimination laws and with the rules and regulations governing fair housing and equal opportunity in housing and employment, including reasonable accommodation provisions
- Define agency expectations of staff conduct, including guidance on professional boundaries.
- Ensure that all participant records containing identifying information are kept secure and all information is handled in a manner that protects participant confidentiality.
- If applicable to the population served, ensure that participants are helped to understand their educational rights, that children and youth are immediately enrolled in school, as required by federal and State law, and that they are connected to educational services to help them succeed in school.
- Include a written grievance policy that (1) defines a process that is accessible to participants with low literacy levels and other barriers; and (2) is posted in an area readily visible to project participants who are receiving services at the agency offices.
- Define a process for managing the client grievance process.
- Ensure that grievance reviews are conducted by a person other than someone who made or approved the decision under review or a subordinate of such a person; and that outreach participants are informed in a timely manner of the outcomes of any grievance.
- Address staff safety and critical incidents.
- Address critical incident reporting and management, including:
  - Defining a critical incident
  - Outlining procedures for critical incident reporting
  - Outlining procedures for critical incident management
- Ensure that homeless services programs are meeting the unique needs of marginalized communities, including people with lived experience of homelessness; people who identify as Black, Indigenous, and People of Color (BIPoC); LGBTQIA+; and people from nations of origin and linguistic groups that are significantly represented in the Houston/Harris County metro region.

Program Administrators and Managers

*Minimum* responsibilities include:

- Examine progress on housing targets with staff. Troubleshoot barriers, identify fixes, and refocus staff on critical tasks through establishment of daily, weekly and/or monthly priority-setting team meetings.
- Support staff effectiveness by reinforcing low barrier and assertive engagement skills and how to build participant motivation (as needed).
- Assist direct care staff to strategically plan concrete daily objectives that are aligned with the project’s performance goals. Program management engagement with direct care staff should occur twice monthly at a minimum.
- Model collaborative service planning and case reviews with direct service teams on a daily basis.
• Revisit the project plans and placement goals regularly, including adjusting canvassing and eligibility documentation strategies as necessary.
• Reinforce the importance of client documentation and development of meaningful service plans, including helping staff to carve out time for these activities if necessary.
• Practice workload management - Clients may require more time at different points in the process. Ensure that staff have adequate time to carry out the most time-consuming activities such as accompanying people on treatment visits, benefits meetings, and landlord interviews.
• Ensure that the outreach team is following safety protocols, including establishing an easy way for frontline staff to give advance notice of where/when they will be, practicing check-ins while staff are in the field, pairing staff for less visible visits, and reinforcing safe behaviors in the field (Daily/as needed).
• Provide information on resources that staff need in order to effectively do their jobs. Develop organizational relationships/memoranda of understanding (MOU) with community-based services and supports that staff will regularly be accessing. Advocate for resources for clients (as needed).
• Support staff self-care by recognizing emotional and psychological needs of staff, acknowledging successes, reinforcing boundaries, managing vicarious trauma and burn-out, and prioritizing support to staff involved in critical incidents with clients (as needed).
• Maintain up-to-date knowledge on The Way Home CoC and non-CoC participating housing options and advise frontline staff on eligibility, rules, and availability (as needed).
• Reinforce the importance of timely, accurate, and complete HMIS data entry. Lead staff through data quality review (quarterly) and make sure they receive all available training on HMIS (as needed).

Note: compliance with minimum standards is not a guarantee of continued TWH funding.

Recommended responsibilities include:

• Develop staff onboarding and orientation plans for all newly hired staff. Monitor staff compliance with required trainings and support ongoing professional development by connecting staff to available opportunities by partner agencies, CoC, or other outreach providers. Track staff participation in trainings.

Coalition for the Homeless

Responsibilities include:

• Coalition (CFTH) staff help to guide system management and provide technical assistance to service provider teams by establishing and monitoring fidelity to local HMIS data standards, Coordinated Access operating policies and protocols, field protocols for supportive service delivery, documentation collection requirements for program participants, and offer/provide provider capacity building trainings as requested.
• Conduct compliance monitoring of contracted agencies for adherence to TWH Program Standards.
• Evaluate system performance and program performance.
• Research promising practices for homelessness assistance initiatives and projects.
• Convene homelessness assistance providers to coordinate services and align strategic objectives.
• Provide or arrange for provider training and capacity building opportunities.
• Aligning programmatic goals and objectives with system goals.
• Operationalize benchmarks for ending chronic homelessness, ending unsheltered homelessness, ending youth homelessness, and substantially reducing homelessness for all populations.

General Standards Applicable to All TWH Homeless Assistance Projects

Training
Funders of The Way Home CoC are responsible for coordinating, offering, making available and/or providing funding for training to meet the standards defined in this Guide.

Training is provided by trainers with expertise and practical experience. Employers of project staff are responsible for ensuring their staff attend, participate in, and complete the necessary training, as well as keeping a record of all program training that is completed by each project staff persons who is employed by their agency. Funded organizations may provide the training to their own staff “in house”, subject to approval from their funder.

Unless specifically noted otherwise, all training requirements identified in this Guide pertain to all TWH CoC staff, regardless of the specific CoC component (i.e. CA Assessors, Outreach, Diversion, Navigation, Case Management).

Training Topics:

The following training topics do not need to be offered as stand-alone offerings; many topics can and should be consolidated into a single, comprehensive training curriculum.

Diversity, Equity and Inclusion training shall be completed within six months of starting employment as TWH CoC staff, unless completed within the past two years prior to initial employment. Training shall be refreshed at least once every three years thereafter.

Training on documentation, including case notes, and the use of HMIS, especially as it pertains to the specific roles in pre-navigation and Coordinated Access intakes, shall be completed within the first month of starting employment as a TWH staff and shall be refreshed once every three years thereafter, or sooner if there are substantial changes to documentation standards or the expected use of HMIS.

Progressive engagement training shall be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and shall be refreshed once every three years thereafter.

Trauma-informed care training shall be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and shall be refreshed once every three years thereafter.

Harm reduction training shall be completed within six months of starting employment as a TWH CoC staff unless completed within the past two years, and shall be refreshed once every three years thereafter.

Training on substance use disorders shall be completed within six months of starting employment as a TWH CoC unless completed within the past two years, and shall be refreshed once every three years thereafter.

Mental health first aid training shall be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and refreshed once every three years thereafter.
Training on **mental health recovery** shall be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and shall be refreshed once every three years thereafter.

Training on **self-care and vicarious trauma** shall be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and shall be refreshed once every three years thereafter.

Training on **professional boundaries** shall be completed within three months of starting employment as a TWH CoC staff, unless completed within the past two years, and shall be refreshed once every three years thereafter.

Training on **staff personal safety** shall be completed within the first month of starting employment as a TWH CoC staff and refreshed once every three years thereafter.

Training on effective **goal-setting** (SMART goal setting) shall be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and refreshed once every three years thereafter.

**Crisis Intervention** training shall be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and refreshed once every three years thereafter.

**Human Trafficking** training shall be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and refreshed once every three years thereafter.

These trainings can be incorporated into a single training offering as a comprehensive staff capacity building effort with multiple subtopics.

**Recommended Training Topics**

**Motivational interviewing** training should be completed within six months of starting employment as a TWH CoC staff, unless completed within the past two years, and shall be refreshed once every three years thereafter.

**First aid and CPR** should be completed within three months of starting employment as a TWH CoC staff unless current certification is already in place and shall be refreshed as necessary to ensure street outreach staff maintain certification.

Training on **overdose response** and the administration of Narcan should be completed within three months of starting as TWH CoC staff, unless completed within the past two years, and refreshed once every three years thereafter. Training in Narcan does not obligate TWH staff to administer the intervention.

**Coordinated Access System (CA) & Homeless Management Information System (HMIS)**

Access to TWH crisis services and programming is available via three distinct pathways: persons seeking assistance may call the CA intake line, they may access CA intake and assessment services in-person at one of the regional Coordinated Access hubs, or persons may access TWH crisis services through direct contact with an Outreach team member.

With the exception of Outreach, which may contact and engage clients without first receiving a referral, the Coordinated Access system (CA) will be the sole source of referral and placement into TWH projects (Diversion, Navigation, Rapid Rehousing, and PSH). Homeless individuals and families will be assessed at CA Assessment Hubs located throughout the Continuum of Care (CoC) and through a designated CA Intake Line. After receiving an CA assessment eligible persons will then be matched to appropriate interventions, prioritized for referral, and matched to available services and housing supports.

Eligibility for one of the TWH interventions is determined by a trained CA Assessor. This assessor will use the
guidance established with local and federal funding streams to ensure eligibility for assistance based on regulatory requirements including homeless status and household composition. Referrals for assistance are done only through the CAS using the CoC’s Housing Prioritization Tool.

All eligible participants enrolled in TWH CoC projects must collect a minimum of Universal Data Elements from program participants and enter those data into HMIS.


Coordinated Access Assessors

What is CA Assessment
The Coordinated Access system exists to coordinate and strengthen access to housing for families and individuals who are homeless or at risk of homelessness throughout the city of Houston and Harris, Fort Bend, and Montgomery Counties. Coordinated Access institutes a consistent and uniform assessment and referral processes to determine and secure the most appropriate response to each individual or family’s immediate and long-term housing needs. The assessment is designed to ensure that homeless persons and persons at risk of homelessness are matched, as quickly as possible, with the intervention that will most efficiently and effectively end their homelessness.

The Coordinated Access System is open to all households who meet one of the homeless or at-risk categories set by the US Department of Housing & Urban Development (HUD). The system uses a locally developed prioritization to rank Applicants in order of vulnerability, with the most vulnerable households ranked at the top.

Function of CA Assessors
CA Assessors function as the front door to the Coordinated Entry System for individuals experiencing homelessness. As the initial contact, they provide access to anyone who is seeking assistance with housing to be assessed in a standard and consistent way, and to connect with the housing/services that best meet their needs. Assessors are well trained to ensure clarity, transparency, consistency and accountability for this process. Assessors are ultimately ensuring that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce permanent supportive housing resources.

CA Assessors are staff from designated community agencies. CA Assessors may office out of Assessment Hubs, be designated as the Assessor for their agency, be a member of the CA Intake Line, or be part of a mobile outreach team. All CA Assessors are trained by the CFTH. The “Housing Assessor Orientation” consists of 6 hours of content. Once trained, CA Assessors are formal members of the Coordinated Access Workgroup and required to participate in ongoing workgroup meetings, check-ins, and case conferences.

Key Responsibilities

1. Initial Contact Practices
   • Introduce The Way Home and CA system. When assessors identify clients who have not been previously assessed in HMIS, they should provide an overview of The Way Home. Assessors introduce the Coordinated
Access system and explain that the first step in the process is to determine what type of housing intervention they may be eligible for through a Coordinated Access assessment.

- **Conducting Coordinated Access Assessments.** Once clients have been oriented to the function of Coordinated Access, assessors use HMIS to conduct the Coordinated Access Assessment. Detailed guidance around the components of the assessment can be found in the *Coordinated Access Operations Manual*.

- **Notifying Client of Eligibility Determination.** For clients who have received an assessment, assessors inform clients about the housing intervention that they are eligible for and educate them on the components of those program types.

- **Coordinated Access Enrollment & Case Notes.** Every client who receives a Coordinated Access Assessment, or who is actively pursuing housing through Coordinated Access, maintains an active enrollment in the Coordinated Access program in HMIS. Assessors create this enrollment directly when they conduct the Coordinated Access assessment. Case notes should provide additional details on the activities outlined above, along with how to locate the individual in the future, support networks, and additional needs observed by the assessor.

2. **Centralized Waitlist & Service Coordination**
   - **Placing clients on the Centralized Waitlist.** Once an Assessor completes the Coordinated Access Assessment, they determine if the client should be placed on the Centralized Waitlist based on the guidance outlined in the *Coordinated Access Operations Manual*. The housing prioritization process begins only once a client is placed on the waitlist.
   
   - **Preparing Clients for Housing.** Assessors help prepare the client’s case by collecting and upload documentation that will be relevant for the housing interventions available to them, such as identification and homeless history. Assessors take a dynamic approach when assisting clients with this process to ensure they understand the eligibility requirements that lie ahead and what options they have for preparing their case now.
   
   - **Contact & Living Situation in HMIS.** The Contact & Living Situation is the mechanism for recording interactions with clients as well as the location where they reside. Assessors enter this for every interaction with a client and this data is used to determine when it is appropriate to exit a client. Assessors also enter other relevant services into HMIS to fully document their work with each individual enrolled.

3. **Warm Hand-offs & Care Coordination**
   - **Ongoing rapport building.** Assessors take a dynamic approach to rapport building with the clients they assist over time. Training in active listening, motivational interviewing, harm reduction, and trauma informed care are core elements of the housing first approach. As additional needs are identified with their clients, assessors assist clients with information and referrals for mainstream services that can help meet those needs.
   
   - **Informing Clients of Referral Decisions.** Assessors provide the primary point of contact for their clients to access information about housing program referrals and decisions. Many clients do not have current contact information, so assessors should remain accessible to clients for routine check-ins.
   
   - **Connecting With Assigned Housing Navigator.** While the *Coordinated Access Operations Manual* clearly defines the housing navigation process, assessors play a key role in assisting clients with connecting to their housing navigator. When possible, connections should be made in the form of a warm handoff, where assessors and housing navigators meet together and discuss the change with the client directly. Housing navigators will be responsible for assisting
the client until they have signed and lease and moved in, and assessors should continue to help clients connect back to the housing navigator as needed.

Exiting a Client

1. Reasons for an Exit from Coordinated Access
   a. The client has not been contacted or located after 90 days of repeated attempts by CA staff. Attempts must include by contacting client directly as well contacting other co-enrolled providers, as identified on the HMIS client dashboard.
   b. Client is deceased
   c. Client has moved into permanent housing
   d. Client has self-resolved their homelessness
   e. Client has made threats of harm directed at Coordinated Access staff and the program is unable to continue serving the client due to risk of violence or harm

Outreach

Purpose of Outreach Practice Standards
✓ Reinforce a shared understanding among CoC partners of the baseline standards for the provision of outreach services and the role that outreach plays in advancing system goals
✓ Improve the coordination of outreach services among practitioners

Outcome of Outreach Practice Standards
✓ Substantially reduce unsheltered homelessness in The Way Home CoC
✓ Large and medium-sized encampments are decommissioned

Process for Standardizing Outreach Practice
✓ The Way Home CoC adopts the outreach Practice Standards Guide as the benchmark for baseline expectations of outreach
✓ All system outreach providers adhere to the Practice Standards Guide and coordinate the delivery of outreach services through geographic assignments of coverage areas

Outreach refers to a CoC program component designed to provide essential services necessary to reach out to individuals experiencing unsheltered homelessness by meeting individuals where they are at both physically and psychologically. Program design includes engaging and developing relationships with people experiencing homelessness in unconventional settings such as campsites, public parks, bus/train stations, highway exit or entrance ramps, abandoned buildings, under bridges, or other places not meant for human habitation. U.S. Department of Housing and Urban Development (HUD) further describes the essential elements of outreach at CFR 576.101:

providing essential services necessary to reach out to unsheltered homeless people; connect them with emergency shelter, housing, or critical services; and provide urgent, non-facility-based care to
Unsheltered homeless people who are unwilling or unable to access emergency shelter, housing, or an appropriate health facility.

Types of Outreach

For purposes of this Guide, Outreach will be further organized into three (3) distinct approaches, each with a defined set of service delivery expectations.

- **General** Community Outreach
  Community Outreach refers to outreach activities exclusively focused on engagement, comfort, and care. Community Outreach is not currently integrated into the CoC’s coordinated outreach response, but Community Outreach services provide a valuable and necessary component of the community’s overall response to unsheltered homelessness.

- **Focused** Outreach & Engagement
  Outreach and Engagement refer to service providers and teams engaged in outreach with multiple sets of agency-specific and community-driven goals that inform outreach work, some of which are not exclusively about housing (i.e. navigation, housing placement, housing retention). Outreach & Engagement includes specialized teams focusing on unique health needs of persons living with HIV/AIDS, teams addressing the specialized needs of youth, Veterans, and/or persons who are victims of sex trafficking.

- **Specialized** System Outreach
  System Outreach refers to a CoC-wide focus, across multi service provider teams and agencies, and integrating services and resources from multi public and private sources. The emphasis is on housing-focused assessment, system navigation, and encampment response.

Function of System Outreach

1. Focused on assisting individuals living unsheltered in our tri-county region, outreach teams facilitate immediate access to partners of The Way Home who provide and/or offer PSH, low barrier shelters, and other temporary shelter accommodations.
2. Assist in encampment decommissioning planning, execution, and monitoring processes. Ensure encampment residents receive wrap-around services and support throughout the closure process.
3. Coordinate with site-based crisis housing and permanent housing providers to ensure clients receive appropriate warm hand-off to the next level of care (i.e. navigation support).
4. Facilitate access to low-barrier shelter and other temporary accommodations, as appropriate.
5. Leverage both mainstream housing and healthcare resources to assist in their efforts to end unsheltered homelessness and stabilize individuals and their families in housing and increase access to income opportunities (either through employment or access to public benefits) for those experiencing homelessness.
6. Provide specialized and targeted outreach during extreme weather events and public health crises, to ensure unsheltered persons have access to emergency services, information, and temporary housing supports.
7. Provide data-driven solutions to community members (general public and elected officials) who might otherwise address unsheltered homelessness through punitive incarcration, loitering fines, trauma-inducing harassment, etc.

8. Provide “comfort and care” supports (engagement and service activities not directly tied to housing).

**Risks & Personal Safety**

Street outreach staff perform their work in community and may witness or encounter firsthand risks that are inherent in serving people who are street involved and/or living outdoors. Risks might include threats of physical violence or harm and exposure to illegal activity occurring on the street. Street outreach staff are responsible for reducing the impacts of those risks whenever possible, as per their training, and supports provided by or through their employer. In some instances, street outreach staff feel their personal safety is jeopardized. When situations and/or locations are unsafe outreach staff can refuse to engage in a location or with particular people that they deem to be too high-risk. These instances shall be reported to the supervisor of the street outreach team.

Street outreach staff and their employer are responsible for promoting personal safety of street outreach staff and taking the necessary measures to decrease risks as is reasonable in the context of street outreach, as per their training on staff safety.

In the event of a real or perceived imminent risk, street outreach staff shall remove themselves from the real or perceived imminent risk. These instances shall be reported to and tracked by their supervisor. Incident reports will be analyzed at a system level to assess policies and protocols to ensure personal safety of outreach staff.

Street outreach staff shall inform their supervisor of their planned locations during their outreach shift, and shall update their supervisor, as appropriate, if there are deviations from the planned locations identified for the shift.

**Service Delivery Strategy (how to approach the work of Outreach)**

There may be a perceived power differential between the street outreach staff and the unsheltered person being served. Street outreach staff shall be sensitive to this power dynamic in every exchange with an unsheltered person and work to ensure the potential power imbalance does not prevent or stall the effectiveness of the engagement and subsequent services with the unsheltered person.

Empathy and compassion are necessary for effective engagement. The street outreach worker engages and supports unsheltered people by seeing the relationship as one of equals (statement works but wording is weird). Street outreach workers shall be non-judgmental in each encounter with an unsheltered person experiencing homelessness.

A person-centered, strength-based, progressive approach is encouraged for effective street outreach engagement and supports. Street outreach workers shall create service support plans, using the TWH document checklist, based upon the specific needs and presenting issues of the unsheltered person and leverage the strengths of the individual to help them create and act on a plan to resolve their homelessness.

Trauma and its impacts are widespread within the unsheltered homeless population, and as such, street outreach staff will employ a trauma-informed approach to reduce trauma associated with encounters. The guiding principles of a trauma-informed approach shall be employed in the work of street outreach (Trauma is used too many times, need to think more on how to word this)
**Key Responsibilities**

### 1. Initial Contact Practices

- **Identifying who is living unsheltered within a defined geographic area.** Outreach workers physically canvass, receive referrals from key partners, and get “tips” from the public about people who may be living unsheltered.

- **Assess the situation for safety.** Once an individual is identified as living unsheltered, Outreach workers first objective is to make contact and assess the situation. Outreach workers complete a 360 scan to identify any immediate, acute medical needs, chronic physical or behavioral health problems, imminent risk of suicide, homicide, or other harm. The initial assessment is an opportunity to involve emergency responders or offer something to reduce the individual’s personal risk, harm, or discomfort.

- **Building rapport and credibility as a street outreach worker.** Outreach workers forge primary relationships with people living unsheltered, earning their trust through consistent and reliable interactions where workers can demonstrate kindness and helpfulness and establishing credibility.

- **Client Centered Approach.** Outreach workers take a dynamic approach, requiring a range of interventions. Interventions on street outreach are tailored towards what the individual is able or willing to receive. The initial contact can include a simple greeting, supplies to increase comfort, food provisions, benefits assistance, a Coordinated Access assessment, pre-navigation, or all the above.

- **Enrollment in Outreach program services.** Every person who is experiencing unsheltered homelessness and encountered by an Outreach team member should be enrolled in HMIS. Street Outreach enrollments include Universal Data Elements, Current Living Situation, and Case Notes. Case notes should contain details on the activities outlined above, along with how to locate the individual in the future, support networks, and potential fit for supportive services in the future (PATH, SOAR, VA, DV, etc).

### 2. Coordinated Access & Pre-Navigation

- **Assessing client for housing eligibility.** Outreach workers provide individuals experiencing unsheltered homelessness with the opportunity to begin the Coordinated Access assessment where they reside. Outreach workers must discuss Coordinated Access by the second contact and begin exploring their housing history and hopes for the future. When unsheltered individuals are interested in completing a Coordinated Access assessment, Outreach workers directly assist with the assessment. This is the primary intervention that Outreach brings to the street.

- **Initiating pre-navigation work.** Outreach workers drive pre-navigation with individuals experiencing unsheltered homelessness. Once the Coordinated Access assessment is complete, Outreach workers provide an overview of the Coordinated Access process, including clear guidelines on any steps the individual will need to follow in the process. Outreach workers then collect any relevant documentation that the individual has on-hand, co-create a pre-navigation plan to obtain eligibility documents, and explains what to expect for follow-up.

- **Creating a Pre-Navigation Plan.** Outreach workers support individuals they are engaging with establishing a plan to obtain eligibility documentation for permanent housing. All those who are engaged in the Coordinated Access process must have a pre-navigation plan that includes action steps towards this end. Pre-navigation plans must be documented in the client’s case notes.

- **Warm Handoffs.** Outreach workers continue to build relationships with individuals living unsheltered until they have moved into housing. Once clients are referred to a permanent housing program, Outreach
workers must provide a warm handoff to introduce them to the assigned housing navigator, unless they are providing housing navigation directly. During the housing navigation process, outreach workers must continue to advocate for and coordinate care with their clients.

- **Date of Engagement in HMIS.** The Date of Engagement is the date on which an interactive client relationship results in a deliberate client assessment or beginning of a case plan. Outreach workers enter this date when the client agrees to complete a Coordinated Access assessment or begins working on any other goal.

3. **Progressive Engagement**
   - **Practicing progressive engagement.** Outreach workers continue to follow-up individuals who they have engaged on a weekly basis. Regular follow-up with individuals experiencing unsheltered homelessness plays an important role in maintaining credibility and progressing through the Coordinated Access and Pre-Navigation process.
   - **Ongoing rapport building.** Outreach workers take a dynamic approach to rapport building. Training in active listening, motivational interviewing, harm reduction, and trauma informed care are core elements of this approach. Outreach workers may leverage supplies, like coffee or hygiene, to provide care and increase comfort. However, these supplies should be used as a tool to build rapport and not as a hand-out.
   - **Following up with those who are dis-engaged.** All clients enrolled in an outreach program who decline previous offers of housing must be contacted, re-engaged, and offered new housing options every two weeks. These interactions should aim to build credibility and further rapport. Enrolled clients who are not actively engaging in their housing plan should remain enrolled in Outreach as long as clients are contacted at least once every 90 days.
   - **Current Living Situation in HMIS.** The Current Living Situation is the mechanism for logging contacts made with clients as well as their current location. This should be entered for every contact made and will be used to determine when it is appropriate to exit a client. Outreach workers should enter other relevant services into HMIS to fully document their work with each individual enrolled.

### Exiting a Client

- **Reasons for an Exit from Outreach**
  a) The client has not been contacted or located after 90 days of repeated attempts by outreach services. Attempts must include site specific search at the last known location of the client, phone calls, and attempts to locate the clients identified point of contact.
  b) Client is deceased
  c) Client has moved into permanent housing
  d) Client has self-resolved their homelessness
  e) Client has made threats of harm directed at outreach staff and the program is unable to continue serving the client due to risk of violence or harm

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**Diversion**

Diversion is the practice of housing-focused problem-solving conversations paired with limited financial assistance offered to persons seeking emergency shelter or residing in emergency shelters. Diversion providers will assist CoC partners in reducing length of stay in area shelters by rapidly resolving primary contributors to the clients housing
crisis. Diversion interventions will often explore strategies such as reunification with friends and family who can host the client safely; returning to a home jurisdiction where the client might experience a strong, more reliable support network; and provision of modest financial and material assistance to set up the client in a new housing situation.

**Referral and Enrollment**

The Coordinated Access Assessment System will be the sole source of placement into Diversion projects. Homeless individuals and families will be assessed at CA Assessment Hubs located throughout the CoC and through a designated CA Intake Line.

**Eligibility and Documentation**

1. Once Coordinated Access directly refers a client to a Diversion project, the Diversion case worker (case manager or Navigator) will screen the client to determine if they meet the definition of homeless. For Diversion, the client must meet criteria for the program.

2. The team will make 3 attempts over 7 days to contact the client. The Case Manager’s first contact attempt must be made immediately or no less than 24 hours after referral. Alternative ways to contact the client are emailing the assessor, reviewing the dashboard for recent enrollments, adding a flag in HMIS, and using any emergency contact info. Referrals cannot be closed out until all methods have been tried.

3. Eligibility will be determined primarily by third-party documentation as the desired form of documentation. Secondly, intake worker observations may be used as documentation of homelessness, and last, and only on rare occasions may certification from the person seeking assistance serve as documentation.

4. For homeless documentation purposes, the referral date will be used as the eligibility date.

5. Clients enrolled in a transitional housing program at the time of the referral are not eligible.

6. Eligibility documentation is the most important document collected.
   a. Homeless documentation needs to state that the third party has witnessed the clients sleeping in an emergency shelter, on the streets, vehicle, or another place not meant for human habitation. The homeless verification letter can be written by a service provider or even a community member.
   b. A Notice to Vacate, Eviction Notice, or a Statement Letter from a third party documenting that the client is at risk of losing their housing within 14 days are also acceptable.
   c. Ask your supervisor if you are not sure that a document can be accepted.

7. Clients who are not citizens are able to submit valid visas, green cards, or passports as a form of ID.
   a. If clients are not citizens and do not have the alternative valid forms of ID that are accepted, this may impact their eligibility in your program and/or the portion of rental assistance that they can receive.
   b. Follow up with your Supervisor to get specifics on how citizenship impacts client eligibility and rental payments for your program. If the client is not eligible for your program, inform CA so they can refer the client to a program that they are eligible for.

8. Birth certificates are not required documents to accept a referral or a housing program.

9. Programs paying their own rent do not need an ID, birth certificate, social security card or valid green card/visas/passport to pay rent for a client.
10. Tax credit properties may require additional documents. Consult with your Supervisor for any property specific requirements or application protocols.

11. Income documentation will also need to be collected to determine the client’s portion of rent. The rental portion is based on your program guidelines. Check with your supervisor to see how it is calculated. To review the documents needed, see the income certification section.

12. When referred from CA, some clients may have a few of the documents listed above already uploaded in HMIS. If the client does not have these documents collected, the CM/NAV assigned to the client must assist the client in collecting what is needed. Some clients will be able to collect documents on their own while others may need assistance securing each document.

a. Clients taking longer than 30 days to collect documents must be staffed with a supervisor to determine if the case should be given an additional 2 to 4 weeks.

b. If the supervisor grants additional time to collect documents, and the documents have not been collected, contact the Housing Associate at CFTH that is overseeing your project to determine the next best steps.

Navigation

Roles and Expectations

1. Housing Navigators are responsible for supporting households through the process of securing permanent housing and accessing disaster relief resources. Some of these activities will include, but are not limited to:
   a. Collecting and uploading necessary documentation into the HMIS. Required documentation includes the following:
      i. Verification of Homelessness (VoH)
      ii. Identification – state ID, driver’s license, HOT ID, Birth Certificate, SS Card
      iii. Verification of Disability (VoD) (if referred to PSH)
      iv. Income Verification (if client has income)
   b. Securing financial assistance
   c. Providing transportation assistance
   d. Accompaniment to potential housing options prior to the client signing a lease
   e. Preparation to leave shelter
   f. Communication with exiting transportation
   g. Participation in Exit Logistics Team meetings, etc.

2. Navigators will have a caseload of 15 to 20 households.

3. All Navigation staff must complete the following:
   a. New user training to get access to HMIS
   b. Coordinated Access Assessment training
   d. Complete the Navigation module and the Housing module for the housing type you are navigating for.
4. Staff are expected to participate in ongoing meetings for Navigation and Outreach staff in our system. Navigation staff should shadow an outreach team, visit assessor hubs, and tour a housing site as part of their onboarding process.

**Eligibility**

1. Once Coordinated Access directly refers a client to a team, the Navigation case manager/navigator will screen the client to determine if they meet the definition of homelessness. The team will make 3 attempts over 7 days to contact the client. The Case Manager’s first contact attempt must be made immediately or no less than 24 hours after referral. Alternative ways to contact the client are accompanying the outreach team, emailing the assessor, reviewing the dashboard for recent enrollments, adding a flag in HMIS, and using any emergency contact info. Referrals **cannot** be closed out until all methods have been tried.

2. The CM/ NAV will make an initial appointment with the household to discuss the housing option they would be eligible for with the program. This will allow the client to determine if the program is something in which they want to move forward with.
   a. If the client agrees to the program, the first step will be to get homeless verification. If the head of household wants to add additional members to the household, they do not have to meet the homeless definition. Only the head of household must meet the definition.
   b. If the client declines the program, the referral must be closed out and a new referral should be requested.

2. The navigation staff are responsible for making a final determination of the client’s eligibility for the housing and/or service project to which the client has been referred. The “referred to” provider must maintain eligibility documentation and backup to support final eligibility determinations.
   a. Contact needs to be made immediately. Staff will make 3 attempts over 7 days to contact the client.
   b. Alternative ways to make contact with the client are emailing the assessor, reviewing the dashboard for recent enrollments, adding a flag in HMIS, and using any emergency contact info. Referrals cannot be closed out until all methods have been tried.

3. Eligibility will be verified primarily by third-party documentation as the desired form of documentation. Secondarily, intake worker observations may be used as documentation of homelessness, and last, and only on rare occasions may certification from the person seeking assistance serve as documentation.
   a. PSH and RRH staff have 14 days to produce homeless documentation. In rare instances a client with high barriers may require additional engagement and verification work to secure a VOH.
   b. Extensions may be given on a case-by-case basis only through consultations with the Supervisor. After the referral has been open for 30 days and a VOH has not been verified and the staff member would like more time to get a VOH, it must be staffers with CFTH Housing Staff.

4. For homeless documentation purposes, the referral date will be used as the eligibility date.

5. Clients enrolled in a transitional housing program at the time of the referral are not eligible.

6. Homeless documentation is the most important collected. Documentation needs to state that the third party has witnessed the client sleeping in an emergency shelter, on the streets, vehicle, or another place not meant for human habitation. The letter can be written by a service provider or even a community member. Ask your Supervisor if you are not sure that a document can be accepted.
7. Until our homeless system has ended chronic homelessness, PSH programs will require chronic homeless documentation for eligibility and a VOD.

8. When documenting chronic homelessness, third party documentation for a single encounter with a homeless service provider on any single day within one month is enough to consider the individual as homeless for the entire month unless there is evidence of a break (e.g. HMIS).
   a. At least 9 months of the 1-year period must be documented by one of the following:
      i. HMIS data (e.g. shelter stays or outreach contacts/services)
      ii. A written referral
      iii. A written observation by an outreach worker
   b. At least 3 occasions must be 3rd party verifications
   c. A 4th occasion may be documented by self-certification with no other docs needed.

9. While most properties will require some current form of identification to apply for an apartment, clients won’t need an ID to be enrolled in the program or to submit a housing packet. If an ID is not collected before the housing packet is ready to be submitted, a declaration for missing ID can be submitted for anyone 18 years old and older if you are applying through HHA or HCHA.
   a. In most cases, a HOT ID can be used in place of a state ID.
   b. Clients who are not citizens are able to submit valid visas, green cards or passports as a form of ID.
      i. If clients are not citizens and do not have the alternative valid forms of ID that are accepted, this may impact the portion of rent that they are responsible for.
      ii. Follow up with the Supervisor for the program which you are navigating to get specifics on how citizenship impacts rental payments for the program.

10. Clients can be enrolled without a social security card. However, in most cases, everyone in the household will need a social security card before you can submit a housing packet with HHA and HCHA. Typically, HHA and HCHA will move forward with the application if they receive a receipt from the Social Security office with their social security number on it stating that a new card has been ordered and will be mailed to the client. On a case-by-case basis, other official government documents that list the client’s social security number may also be accepted (i.e., school records, Medicaid/Medicare documents, etc.). Some of the clients who are enrolled in the program have various states of citizenship. This may range from clients who are citizens, green card/visa holders, asylum seekers, or clients who may have crossed one of the boarders illegally. Any client that is homeless is eligible to participate in RRH regardless of citizenship status.
    a. Contact HHA for additional information on how citizenship impacts rental payments for your program.
    b. Confirm documents that can be accepted by HHA and HCHA

11. Birth certificates are not required documents for an enrollment in the program. Adults are not required to have a birth certificate to submit a housing application however, any minors in the household will need one. If a client has a birth certificate, it should be included in the housing packet. If birth certificates are not collected before the housing application is ready to send to the housing authorities, a declaration for missing birth certificates must be completed for everyone in the household.

12. If you are navigating for a program that administers their own rental assistance, you will be collecting the same documents for eligibility.
Enrollment

1. Once homeless documentation is confirmed, the client/household can be enrolled. The enrollment process consists of the enrollment forms and the enrollment workflow in HMIS. The enrollment you use for your clients is specific to your agency and the grant that funds the services you provide. Check with your Supervisor to confirm the name of your HMIS enrollment.

2. Once completed, all enrollment documentation must be uploaded into HMIS. The original documents will be kept in the file.

3. While rental history or criminal backgrounds do not factor into eligibility for our services, some of the housing programs we work with may have a background criterion that they follow.
   a. Discuss with the client what kind of history they have. This information may impact whether they will be approved for the program they are referred to or which apartments they may be accepted by.
   b. If you’re working with a project-based program and the client will not pass the background check, notify CA that the client was denied and request a new referral. CA will place the client back on the waitlist and will get referred to a different program.

Vouchers/Coupons/RFTAs

Projects utilizing a voucher/coupon/or rental assistance through a PHA will have up to 30 days from the date of program enrollment to submit a housing application. Case Managers and Navigators are responsible for helping the client complete the application. During this time, it is essential to start having conversations with clients about housing to get a sense of what the client is looking for and if they have anything on their rental or criminal background.

1. Clients who have not collected and turned in a voucher application within 30 days must have their case reviewed by the Agency Supervisor to determine if the client can be given additional time.

2. Clients can submit an apartment application after the PHA has approved their housing application, attended a briefing (if applicable), and received their RFTA.

3. RFTAs must be executed within a specific timeframe and utilized within specific zip code ranges. Extensions may be provided on a case-by-case basis through the PHA who issued the RFTA. Confirm any zip code restrictions with your supervisor or assigned CFTH Associate.

4. The process for turning in applications, RFTAs, and other documents to HHA or HCHA will periodically change depending on the vouchers available to the system at that time and program structure. Contact the CFTH Associate overseeing your project to get directions on the current procedures.

5. Before any vouchers/coupons/RFTAs are submitted to a PHA, they must be reviewed by the CM/NAV’s agency supervisor.

Housing Search

1. Due to changes in the local rental market, it has become more difficult to find properties that are willing to accept TWH CoC programs.

2. Setting expectations is a key component in the housing search for all housing programs.
a. RRH and TH-RRH housing programs must have conversations with clients about housing affordability before the client is housed. Planning in advance for the program exits increases the chance of their success.

   i. Housing placements for these interventions are not necessarily meant to be the permanent housing location for each client. A housing placement in these programs should help the client identify what types of household/unit configurations are needed to keep them stably housed and provide an opportunity to increase/safe income or resources.

   ii. PSH programs that require clients to pay a monthly rental portion must set payment expectations at enrollment.

3. Adding roommates or household members are allowed to be added at any point during a program enrollment. If the client is in the navigation phase, this may impact the length of time it takes to get housed. Contact the CFTH Associate overseeing your project for more information.

4. Clients who are referred to a housing program that is tied to a specific unit will have to accept that unit if they want to be housed. If they do not want to get housed at that location, they can turn down the housing option and will be returned to the waitlist. For information on the process and how to document a client turning down a housing option, review the Navigation exits portion of this Guide at consult with a CFTH Associate.

5. Clients referred to a scattered site program may have more flexibility of what options are available. All PSH, RRH, and TH-RRH projects funded through the CoC are given access to The Way Home Inventory List. The inventory is a compiled list of properties that have agreed to work with our housing programs. The CFTH Landlord Engagement Team monitors the list to ensure the information and units available are as up to date as possible. Contact the CFTH Associate overseeing your project for access to the Inventory List.

   a. Clients can be housed at properties that are not on the Inventory List. The inventory is meant to provide updates on available units in our system for housing projects.

6. Before doing an apartment search, scattered site RRH and PSH housing programs must meet with the client to better understand their placement needs (e.g. needing a unit on the first floor, living on the northside, near a family member, or on a bus line).

   a. When collecting this information, the case manager or navigator must set expectations. While the housing preferences must be taken into consideration, there may not be an available unit or property that meets everything on their preference list.

7. Scattered Site housing programs must use the CFTH Housing Inventory. If suitable housing is not identified using the CFTH Housing Inventory and Landlord Engagement Team, the housing program may conduct additional self-identifying searches.

8. Scattered Site housing programs must provide 1-3 options for each client/household to choose from that have an availability and will accept the client.

   a. Each option that the case manager or navigator have identified that has availability within the next 15 days and will accept the client, must be recorded on the Housing Options Form. The completed form must be uploaded into HMIS and placed in the file.

   i. Due to the rental market and criminal/rental backgrounds, it may not be possible to find 3 options that will accept a client or household. Housing programs must identify at least one housing option
that has a vacancy and will accept the client. Programs are not allowed to exit a client because the case manager or navigator cannot locate a unit that will accept the client.

ii. Clients are encouraged to recommend a property they want to live at. Contact information should be passed to the case manager or navigator so they can follow up with the landlord and determine if it is a viable option for the client.

iii. If the case manager or navigator are not able to locate an option for the client within 30 days, staff must consult with the assigned CFTH Associate overseeing the project. They can coordinate with the Landlord Engagement Team to identify other options.

iv. As long as the client remains engaged in the housing process and open to properties suggested by their case manager or navigator, they cannot be exited.

v. Clients cannot be exited because the system is not able to find a unit that will accept them. For more information on exit procedures while a client is in navigation, review the Navigation Exits portion for this manual.

9. Housing programs utilizing a voucher/coupon/rental assistance through a PHA will need to submit a RFTA to the property that accepts the referred client. Case manager or navigator must offer assistance to the landlord to complete the RFTA so it is done correctly and in a timely manner. Once the RFTA is completed, the case manager or navigator must review the RFTA and return it to the appropriate PHA.

   i. Most programs that require a RFTA will also require a dummy lease. Contact the assigned CFTH Associate overseeing the project for more information on the process.

10. Regardless of the housing program type, all lease durations must be set at 12 months. In certain case by case situations, expectations may be made to this rule for RRH projects. Contact the assigned CFTH Associate overseeing the project for when these exceptions are made.

11. Before an inspection can be done on the prospective unit for a client, Rent Reasonableness must be performed to ensure the requested rent is fair in relation to other units at the property. Contact the assigned CFTH Associate overseeing the project for Rent Reasonableness regulations if a PHA is not performing the inspection.

12. All units must pass an HQS inspection before a client is able to sign a lease and move into the unit. Housing programs are not able to pay rental assistance for units that have not passed an HQS inspection. Contact the assigned CFTH Associate overseeing the project for HQS regulations if a PHA is not performing the inspection.

   i. For PHA funded projects, clients must sign their lease within five business days of the inspection.

13. Under the Fair Housing Act, an owner must not refuse the request of a family that contains a person with a disability to make necessary and reasonable modifications to the unit. Such modifications are at the family’s expense. Contact the assigned CFTH Associate overseeing the project for information on making these requests.

14. If a client moves in and the first month’s rent needs to be prorated, proration assistance is calculated based on the actual days in the month. Programs working with a PHA, can request proration calculations.
Declining Housing Options
1. Once a client has been in navigation for 30 days and has been provided with 1-3 housing options that will accept them and has an upcoming vacancy, the client will need to decide if they want to move forward with one of the options or decline the housing program.
   a. The client will need to be notified that they have 14 calendar days to apply and get approved at one of the options that the CM/NAV has provided or get approved at a property that the client has identified on their own and will accept the housing program.

Unit Size Subsidy Standards
Housing rules state that there can be two people in each living space. This also includes the living room. For example, a two-bedroom apartment with a living room can fit up to 6 individuals. While sharing a living room or a bedroom are not always ideal in the long run, it can be much more manageable when trying to end a period of homelessness and gain more stability. Due to the cost of housing increasing, clients need to be encouraged to identify the smallest unit their household can fit into.

The following requirements apply when determining the appropriate unit size for a household:
   i. The subsidy payment standards must provide for the smallest number of bedrooms needed to house a family without overcrowding.
   ii. A child who is temporarily away from the home because of placement in foster care is considered a member of the family in determining the family’s unit size, if it can be verified that the child will be returned to the family when suitable housing is available.
   iii. A family that consists solely of a pregnant person must be treated as a one-person household.
   iv. Any live-in aide must be counted in determining the household unit size.
   v. Contact the assigned CFTH Associate to find the updated FMR for our CoC.

Housing Stability Assistance
1. After move-in assess on-going service needs and connect clients to appropriate services as necessary for at least three months after move-in.
2. Prepare clients for success by thinking through contingencies in advance of housing and mitigating risks to housing stability. Consider the impact of how a client structures their days, roles they play in their social networks, habits and patterns of behavior that could lead to housing stability.
3. Incorporate the expectation of an eventual transition to another provider early in the engagement process. Taking this early step helps to ease transitions later in the process.
4. Actively involve the client in the referral process and attend to the client’s emotional concerns about the transition.
5. Inform the staff of the linkage site about the client’s needs and characteristics and provide them with technical assistance and emotional support for their concerns.
6. Provide follow-up support on a gradually declining basis to both new staff and the client to prevent abandonment issues.
Navigation exits

1. Any household may be terminated from Navigation assistance if deemed necessary by a team in consultation with your Supervisor. Reasons for termination may include but are not limited to:
   a. Incarceration or institutionalization over 90 days. CMs in coordination with the FAI may continue to support households where the head of household receiving assistance is incarcerated or institutionalized for up to 90 days. Any household where the head of household receiving assistance is incarcerated or institutionalized for more than 90 days will be terminated from the program.
   b. CM is unable to contact the household in over 30 days. The case should then be passed on to the Supervisor, so they can attempt to contact the client. If the Supervisor is unable to make contact, the CM can move forward with the exit.

2. Households can be exited if they would no longer like to participate in navigation for a housing program. When possible, clients need to submit this request in writing or email.

3. If clients are terminated from Navigation, the Housing Authority and landlords need to be notified in writing before they are exited in HMIS.

4. If clients want to file a grievance at any point or disagree with their pending exit from the program, work with your supervisor on following the steps laid out in the Grievance Procedure. If the agency is not able to come to an agreement with the client, continue through the policy and contact the Lead Agency and FAI for a resolution.

5. When a client is exited, the termination form must be uploaded in HMIS with a corresponding case note and then placed in the file. Once the document has been uploaded, send an email to HHA notifying them of the exit so they can determine how to proceed with rent payments.

RRH and PSH Case Management

Providers of RRH and PSH services are contracted to do so by TWH funder partners such as City of Houston, Harris County, Texas Department of Housing and Community Affairs (TDHCA), US Department of Housing and Urban Development (HUD), and/or US Department of Veterans Affairs (VA). These RRH and PSH housing providers may be direct recipients of funding or subrecipients of a prime contract holder. For ease of reference all direct service case management providers (both RRH and PSH) are referred to as “providers” throughout this Guide.

Housing First Program Philosophy

The RRH/PSH provider agrees to operate the project under the “Housing First” model and adhere to the following Housing First tenets:

1. Client participation in mental health, substance use, or employment services are not required prior to entering project. Projects must continually offer services even when client declines participation. Projects may need to adjust their case management and service engagement strategies when clients decline to participate.

2. Client choice is valuable in housing selection and supportive service participation.

3. Housing First projects remove barriers faced by prospective and/or current participants trying to attain permanent housing.
4. Housing First projects do not require prerequisites to access housing support beyond what is required in the tenant’s lease.

Referral Source
The RRH/PSH provider must use the CoC’s Coordinated Access System (CA) as the sole referral source.

Eligibility Documentation
1. The RRH/PSH case management staff are responsible for making a final determination of the client’s eligibility for the housing and/or service project to which the client has been referred. The “referred to” provider must maintain eligibility documentation and backup to support final eligibility determinations.
   i. Contact needs to be made immediately. Staff will make 3 attempts over 7 days to contact the client.
   ii. Alternative ways to make contact with the client are emailing the assessor, reviewing the dashboard for recent enrollments, adding a flag in HMIS, and using any emergency contact info. Referrals cannot be closed out until all methods have been tried.

2. Once a RRH or PSH client/household has been confirmed as eligible for a provider’s housing program, the next step is collecting identifying documents for landlords and/or rental subsidies used by the program. All documents must be uploaded in HMIS.

3. Most landlords want a government issued picture ID for anyone in the household that is 18 years or older. In most cases landlords will accept an expired form of ID if it has a picture on it, the information is clear, and matches the information pulled up during a background check.
   i. If a client does not have an ID, there are a handful of community partners that are able to assist with getting IDs. For more information, contact the CFTH Associate that oversees the provider’s housing project.
   ii. If the community partner options are not available, a HOT ID might be accepted in place of a state ID. Contact the CFTH Associate that oversees the provider’s housing project to get more information on what they look like, if landlords will accept it, and how to get one for RRH/PSH case management clients.

4. Clients who are not citizens are able to submit valid visas, green cards, or passports as a form of ID.

5. If clients are not citizens and do not have a valid alternative form of ID, this may impact their eligibility in provider programs and/or the portion of rental assistance that the client can receive.
   i. Follow up with agency leadership or supervisor to get specifics on how citizenship status impacts client eligibility and rental payments for different program funders. If the client is not eligible for the program or will not be able to sustain housing with the rental portion they would receive, inform CAS so they can refer the client to a program that they are eligible for.
   ii. It is important to note that nonprofits operating housing programs are not required to confirm citizenship status. It is only mentioned in this manual to help providers understand how to best support clients that may not receive the full financial support of certain programs.

6. Housing programs that pay rent to the landlord do not need an ID, birth certificate, social security card
or valid green card/visa/passport to pay rent for a client.

7. Several housing programs use a voucher, coupon, or rental assistance through one of TWH local Public Housing Authorities (PHA). These projects may require some form of ID, birth certificates, and social security cards.
   
   i. If anyone in the household that is 18 years or older does not have an ID or a birth certificate when the housing application is ready to be submitted to a PHA, the client can sign a waiver that can be turned in with the housing application so the process can get started. Housing staff are then expected to help the client obtain those documents before they move into housing.
   
   ii. Individuals in the household who are 17 years or younger will be required to turn in a copy of their birth certificate when submitting a housing application to a PHA.
      
      a. If a client does not have a birth certificate, there are a handful of community partners that are able to assist. For more information, contact the CFTH Associate that oversees the housing project
   
   iii. Everyone in the household will be required to turn in a copy of their social security card when submitting a housing application to a PHA.
      
      a. On a case-by-case basis, other official documents that list the client’s social security number may be accepted (e.g. school records, Medicaid/Medicare documents, social security printouts).
      
      b. PHAs will also accept a receipt from a local Social Security office stating that a new card has been ordered. The receipt will need to include the client’s 9 digit social security number.

8. Some housing programs may utilize units at tax credit properties. Those locations may require additional documents. Consult with a program supervisor for any property specific requirements or application protocols.

9. Several housing programs are required to collect income documentation at program entry. All projects review income documentation annually. In most cases, this income information is collected to determine what monthly client portion will be put towards rent. Check with provider supervisors to determine how the client portion is calculated.

10. When a client or household is referred from CAS, some of the documents listed above are already uploaded in HMIS. If the client does not have these documents collected, the CM assigned to the client must assist the client in collecting what is needed. Some clients will be able to collect documents on their own while others may need assistance securing each document.

11. After confirming the client or household has confirmed eligibility and is enrolled into a housing program, CMs have 30 days (about 4 and a half weeks) to collect available the documents needed to submit an application to a landlord or a housing application to a PHA.
   
   i. Clients taking longer than 30 days to collect documents must be staffed with a supervisor to determine if the case should be given an additional 2 to 4 weeks, closed, or sent back to CAS.
   
   ii. If the supervisor grants additional time to collect documents and the documents have not been
collected, contact the CFTH Associate overseeing your project to determine the next best steps.

The Way Home CoC System Participation

All RRH and PSH Case Managers and agency management and leadership staff (managers, supervisors, team leads, etc.) are expected to attend reoccurring workgroups for the contracted project type. If the provider agency has a conflict and cannot attend workgroup meetings, the appropriate CFTH staff hosting the meeting must be notified in advance.

Housing Search & Placement Services

1. Locating housing options for a client must follow the process outlined in the CCHP Manual.
2. Housing and Navigation providers will be responsible for communicating with the necessary partners to ensure the clients on their respective caseloads are leased up and documentation has been submitted so the landlord can receive the agreed upon incentive fees and deposits.
   a. Necessary parties will include CFTH staff, local housing authority staff, landlords, and collaborating homeless service providers.
3. Navigators working with clients must coordinate with the client’s assigned Case Manager to ensure the transfer of service will begin when the client moves into housing and facilitate a warm handoff.
4. Case Managers should make every attempt to be present when a client signs their lease and moves into housing. In the rare instances when the case manager cannot be present at lease signing, the case manager must follow up with a home visit within 48 hours.
   a. Once a client moves into housing, the Case Manager must complete the Program Distinction Form and submit it to the landlord within the first week of the client’s signed lease.
5. Case Managers are expected to review the lease agreement with their client within a week of moving into the unit so the client understands what rules need to be followed to stay housed.
   a. A copy of the lease must be uploaded into HMIS.
6. Case Managers are responsible for ordering furniture, welcome baskets, Landlord Incentive Fees, or ensuring that they have been ordered by the assigned Navigator.
   a. The CFTH Processing Team is responsible for overseeing this community process. The team should be contacted for troubleshooting, training, or general questions.

Home Visits

1. At minimum, the Case Manager will meet with each household on their caseload once a month, in person, at the clients home. Services may need to be offered more frequently and should be adapted to meet the client’s needs. For example, clients in navigation, issues with the landlord, or if the client is having a crisis more frequent home visits will be necessary.
   a. In a Permanent Supportive Housing (PSH) program, the client does not have to participate in services. However, the provider must offer services and make an attempt to engage the client each month.
i. If a PSH client is in jeopardy of losing their housing, this must be communicated to the client regardless of whether or not they want to participate in services.

b. In a Rapid Re-Housing (RRH) program, client participation in monthly services is required for the client to remain enrolled.

c. The required monthly service for RRH and PSH must be completed in person as a home visit.
   i. If the housing provider has a safety or health concern performing a home visit, the in-person service must be performed in a neutral location. Since transportation barriers are very common for clients in TWH programs, the neutral location must be within 2 miles of the client’s home or at other locations deemed private, safe, and accessible by the client and case manager, even if it is not within a 2 mile radius.
      1. Completing an in person visit with 2 staff members is good practice when there is a potential safety concern.
   ii. A home visit to view the status of the unit must be performed every 3 months.
      1. PSH clients do not have to engage in supportive services during this visit. The focus of the visit is to determine the unit does not have any outstanding issues that need to be addressed. This might include habitability or client safety concerns.

2. For RRH and PSH projects, a monthly check in with each client’s landlord via phone, text or in-person must be completed to inquire if there are any issues with rental payments or potential lease violations. Most properties have a main office at the property. These check ins can take place before or after meeting with the client.
   a. If the landlord’s office is closed or they do not have an office on site, a phone call and email should be made to attempt contact with the landlord.
   b. Case Managers must negotiate with landlords to prevent evictions or lease violations and relay the information to clients. Case Managers will work with clients on finding possible solutions to prevent the violation from happening again.

3. RRH monthly services must follow the Service Plan outlined in the CCHP Manual.

4. Housing providers must conduct ongoing internal supervision meetings outside of any CFTH workgroups to ensure staff are adopting housing first/harm reduction best practices and to help troubleshoot issues around maintaining housing, landlord relationships, mental health, substance use, or other barriers that the client may need assistance with.

5. PSH providers must complete an annual HQS inspection prior to official PHA inspections for clients enrolled in their housing programs. This inspection must take place before a lease is renewed so any issues with the unit can be reported and resolved when the new lease is finalized.
   a. Annual inspections are performed to ensure clients are living in a unit that meets HQS.
   b. Annual inspections can also be used as a tool to engage with clients on concerns with their basic needs, harm reduction, lease violations, or stability goals.
   c. If a PSH client does not want to receive case management services, an annual inspection of the unit will need to be performed before the lease can be renewed.

6. Diversion providers must ensure that family reunification strategies include safety and risk assessments for participants. The best risk assessment is accomplished via a home visit/inspection for host homes. When Diversion assistance includes financial assistance to address any rental arrearages, Diversion staff
may need to complete a home inspection to ensure compliance with Diversion funding sources requiring home inspections.

Data Capture & HMIS
1. When a client moves in, their address and housed date must be updated in HMIS.
2. Every meaningful client interaction that advances the clients housing stability plan must be documented in HMIS with the appropriate service and a case note.
   a. Any interaction performed on the client’s behalf (with the landlord, housing authority, referrals for services, etc.) must be documented in HMIS with a case note.
   b. Failed attempts to meet with a client must be documented in a case note.
3. Case notes in HMIS are meant to give a brief summary on the interaction, tasks that have been agreed on, goals, client’s state of mind, housing issues, or any other concerns.
   a. There are several case note templates in HMIS that housing providers can choose from. However, a case note must include a paragraph (about 5 descriptive sentences) to document what has transpired or any updates.
   b. CCHP RRH case notes must incorporate the use of exit planning templates and the topic specific notes. Guidelines for how to utilize these templates are in the CCHP Manual.

Client Transfers
Clients may be transferred from one team to another due to safety concerns or when a grant funding source has been terminated.
1. Agencies have the right to put a hold on receiving a transfer if they have not received copies of the required documents that make up a valid file from the previous agency.
2. The client’s exit date from the previous agency must be the date before the client is enrolled in RRH or PSH with the new agency. The previous and receiving agency will need to coordinate the enrollment/exit dates.
3. The receiving agency must request a referral in HMIS for the client they are accepting.

Client Behavioral Health Wellbeing
1. Housing providers must send a referral for Harris Center Supportive Services or Domestic Violence Mobile Advocate if they are concerned for a client’s wellbeing or believe they need these services based on credible threats of imminent self-harm.
   a. If the client denies the need for the referral or does not wish to engage with the Supportive Service provider, the Housing provider must send the referral to the appropriate Supportive Service provider and ask for case staffing. This will allow the Housing provider the opportunity to learn and incorporate some best practices to help stabilize the client.

Case Termination and Exit Records in HMIS
1. Any RRH participant may be terminated from the program after a determination has been made by both supervisors and CFTH staff. Reasons for termination may include but are not limited to:
   i. Incarceration or institutionalization over 90 days. CMs in coordination with the FAI may continue to support households where the head of household receiving assistance is
incarcerated or institutionalized for up to 90 days. Any household where the head of household receiving assistance is incarcerated or institutionalized for more than 90 days will be terminated from the program.

ii. CM is unable to contact the household in over 30 days. If supervisors are also not able to contact clients, then a case consultation should occur with CFTH to determine if an exit is appropriate.

2. RRH and PSH participants can be exited if they would no longer wish to participate. Clients should submit this request to the CM in writing or via email. Clients and landlords must be notified in writing before clients are exited.

3. Case Managers need to provide an exit or graduation letter to clients that is dated before or on the exit date in HMIS.

4. If clients want to file a grievance at any point or disagree with their pending exit from the program, the Grievance Procedure should be followed. If the agency is not able to come to a resolution with the client, the CFTH should be notified.

5. When a client is exited, a corresponding case note must be entered into HMIS.

Case Loads
After an agency completes the first 90 days of their contract, the agency must maintain 85% of their contracted caseload capacity regardless of their staffing numbers. If agencies anticipate they will not be able to maintain contractually required staffing levels the agency must immediately notify CFTH and work to identify suitable staffing alternatives.

Case Notes
1. Each case note is expected to include basic information about the main topics discussed during a client contact, where the meeting took place, anything that was resolved, any next steps that must be worked on by client/provider, the state of the unit, and the overall well-being of the client.

2. If the case note is meant to document that the client missed an appointment, the above information is not needed.

3. Emergency incidences such as, mental/physical health, safety, law enforcement interactions, or APS/CPS interaction, much be documented in HMIS.

Emergency Transfers for Victims of Domestic Violence
An individual or household who is a victim of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking and is currently residing in a non-DV housing program may request a transfer if: the individual reasonably believes that there is a threat of imminent harm from further violence if the individual remains within the same unit. If the individual is a victim of sexual assault, he/she may also be eligible to transfer if the sexual assault occurred on the premises.

A client/tenant requesting an emergency transfer must expressly request the transfer by notifying their Case Manager. Case Manager and Client will troubleshoot any other possible options to resolve the solution in a safe way. Case Manager and Client will discuss how much of the situation the Client wants to reveal to the Landlord to possibly
resolve the situation. If the situation cannot be resolved and moving the Client is the only option, the Case Manager will contact Coordinated Access and request a transfer.

Coordinated Access will discuss options with the Client and determine if the Client is eligible for a program that has an available space. The Client will be offered the option to go through the DV Coordinated Access process and receive services from a DV provider. In this situation the DV Coordinated Access system will take over and the Client’s record in HMIS will be closed upon transfer. If client declines DV services/programs, Coordinated Access will be the next possible transfer and informs the Client of the program/location. At that point the Client can accept or deny the referral. If the Client approves of the transfer, the Case Manager will complete a warm hand off to the next program, assist with the transfer, and facilitate a mutual rescission with the Landlord. If the Client wants to deny the transfer, they will remain (i.e. stay) at the top of the list and wait for the next vacancy in a program they are eligible for. If the Client is in a Scattered Site program with a voucher or rental assistance through Rapid Re-Housing, the Case Manager can assist the Client with a unit transfer to a safer location.
Definitions/Glossary

**APS**- Adult Protection Services

**Area Median Income (AMI)** – Annual income estimates published annually by the U.S. Department of Housing and Urban Development (HUD) and based on Fair Market Rent (FMR) Areas. For the Houston/Harris County Continuum of Care, the HUD FMR Area is Houston- Woodland-Sugarland. AMI and Median Family Income (MFI) are used interchangeably to determine the income limits for a household eligible for assistance.

**Bridge to PSH** – Short-term housing that provides safe, temporary housing while waiting on a permanent supportive housing intervention.

**CAS**- Coordinated Access System

**Case management** – assessing housing and service needs, arranging, coordinating, and monitoring the delivery of individualized services to meet the needs of the program participant. Standard services and activities are as follows:

(i) using the centralized or coordinated assessment system as required under § 576.400(d);
(ii) conducting an initial evaluation of housing barriers and needs § 576.401(a), including verifying and documenting eligibility for various programs;
(iii) counseling;
(iv) developing, securing and coordinating services;
(v) obtaining Federal, State, and local benefits;
(vi) monitoring and evaluating program participant progress;
(vii) providing information and referrals to other providers; and developing an individualized housing and service plan, including planning a path to permanent housing stability.

**Case Manager (CM)** – A staff person whose primary role is providing supportive services to ensure formerly homeless individuals maintain their housing. Services can vary and should be tailored to meet the needs of the individual. Some case managers can also serve as Navigators while the individual is going through the housing process.

**Centralized Waitlist**. After you have completed an Assessment, you will be placed on the Centralized Wait List. The Central Wait List is a prioritized list of households needing housing. It is ranked by a scale of vulnerability based on various criteria which was collected during the assessment.

**CPS**- Texas Child Protective Services (DFPS)

**Chronically Homeless** – An individual or adult head of household with a disability who is living in a place not meant for human habitation, a safe haven, or an emergency shelter and who has been living as described continuously for at least 12 months, or on at least 4 separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months.

**Continuum of Care (CoC)** – The local planning body responsible for coordinating the full range of homelessness services in a geographic area. The local Continuum of Care (CoC), identified by HUD as the Houston/Harris County Continuum of Care, covers the geographic area of Houston, Harris County, Montgomery County, and Fort Bend County and is governed by the CoC Steering Committee.
**Community COVID Housing Program - CCHP**

**Coordinated Access (CA)** – A process developed to ensure that all people experiencing homelessness have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs. CA is not a project but rather a housing assessment. The assessment generates a vulnerability score. Individuals and families are referred to housing based on this vulnerability score, with the highest scores being referred first.

**Coordinated Access Referral** – A referral to a RRH or PSH project, which is generated in HMIS. This serves as formal notification to the project that an individual or family is being referred for a housing intervention.

**Engagement** – activities to locate, identify, and build relationships with unsheltered homeless people and engage them for the purpose of providing immediate support, intervention, and connections with homeless assistance programs and/or mainstream social services and housing programs. These activities consist of making an initial assessment of needs and eligibility; providing crisis counseling; addressing urgent physical needs, such as providing meals, blankets, clothes, or toiletries; and actively connecting and providing information and referrals to programs targeted to homeless people and mainstream social services and housing programs, including emergency shelter, transitional housing, community-based services, permanent supportive housing, and rapid re-housing programs. Note that Date of Engagement is an official event in HUD HMIS data entry guidance and refers to the date a client’s housing plan is developed.

**Exit** – when an individual or household is removed from service via HMIS because of program completion, transition, termination or relinquishment.

**Exit Destination** – A place where an individual or family ends up after exiting RRH or PSH. The goal for both of these interventions is for the exit destination to be permanent.

**Fair Market Rent (FMR)** – The estimated amount (base rent + essential utilities) that a property in a given area typically rents for. Annual listings of FMR can be found at


Below is the 2021 FMR for the Houston, Woodlands, Sugar Land, & Harris County Metro Areas:

<table>
<thead>
<tr>
<th>Year</th>
<th>Efficiency</th>
<th>One Bedroom</th>
<th>Two Bedroom</th>
<th>Three-Bedroom</th>
<th>Four-Bedroom</th>
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<tr>
<td>FY 2021</td>
<td>$893</td>
<td>$968</td>
<td>$1,157</td>
<td>$1,551</td>
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<tr>
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<td>$908</td>
<td>$1,096</td>
<td>$1,485</td>
<td>$1,878</td>
</tr>
</tbody>
</table>

**Family** - includes, but is not limited to, regardless of marital status, actual or perceived sexual orientation, or gender identity, any group of persons presenting for assistance together with or without children and irrespective of age, relationship, or whether or not a member of the household has a disability. A child who is temporarily away from the home because of placement in foster care is considered a member of the family. 24 CFR 5.403

**Financial Assistance Intermediary** - Agency responsible for the management, distribution and reporting for all financial assistance available through City HOME TBRA funding only. The FAI for CCHP is the Houston Housing
Authority (HHA). Not all CCHP agencies will work with HHA.

**Harris County Housing Authority (HCHA)** – The Harris County Housing Authority manages the rental assistance for some of our PSH housing programs.

**Homeless Management Information System (HMIS)** – A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. HMIS usage is required by HUD. The local HMIS is Client Track.

**Homeless Outreach Team (HOT)** – Teams of Houston Police or Harris County Sheriff Officers that provide services to individuals living unsheltered throughout Houston & Harris County.

**HOT ID** – A photo ID that is obtained from Homeless Outreach Teams from the Houston Police Department or the Harris County Sheriff’s Department.

**Household or Family** – one or more persons who live together

**Housing First** – A model of providing housing to homeless individuals that focuses on providing services to individuals once they are in housing to assure housing stability and does not require sobriety, medication compliance or agreement to participate in specific services as a condition of receiving assistance.

**Literally Homeless** – An individual or family who is living in a place not meant for human habitation or in an emergency shelter.

**Houston Housing Authority (HHA)**- The Houston Housing Authority manages the rental assistance for several of our housing programs.

**Mental Health Treatment** – the direct outpatient treatment by licensed professionals of mental health conditions operating in community-based settings, including streets, parks, and other places where unsheltered people are living. **Mental Health Treatment** is only appropriate for Street Outreach to the extent that other appropriate mental health services are inaccessible or unavailable within the jurisdiction. Mental Health Treatment is intended to be delivered by a licensed clinician. Mental health services are the application of therapeutic processes to personal, family, situational, or occupational problems in order to bring about positive resolution of the problem or improved individual or family functioning or circumstances. Standard treatment consists of crisis interventions, the prescription of psychotropic medications, explanation about the use and management of medications, and combinations of therapeutic approaches to address multiple problems.

**Move-In Date (aka lease-up date)** – The date that the household moved into RRH or PSH.

**Navigator (NAV)** – A staff person whose primary role is working with clients from the point of referral through the housing move-in date

**New Hope Housing (NHH)** – Largest SRO affordable housing developer in Houston. NHH properties are built using tax credits and units are typically subsidized via project-based housing choice vouchers through HHA.

**Permanent Supportive Housing (PSH)**- A housing intervention for singles or heads of households with disabilities that combines rental assistance paired with supportive services. PSH is permanent and designed to serve the most vulnerable in a community. In order to be eligible for PSH an individual or family must be chronically homeless.
**Pre-Navigation** - the action of working with a client to collect the 4 essential documents to be Navigation ready (ID, Social Security Card, VOD, and VOH).

**Project Exit Date** – The date when the household left the project and no longer receives services.

**Project Start Date (aka Enrollment Date)** – The date that the household begins receiving services from a RRH or PSH project. This is not necessarily the move-in date, although in same cases these can be the same.

**Public Housing Authority (PHA)** – A government body that facilities rental payments for qualified residents. The PHAs (Public Housing Authorities) our programs utilize the most are HHA and HCHA.

**Rapid Re-Housing (RRH)** – A housing intervention designed to provide rental assistance and case management to help singles and families that don’t need intensive and ongoing supports to quickly exit homelessness and return to permanent housing. Rapid Re-Housing is a temporary intervention. In order to be eligible for RRH an individual or family must be literally homeless.

**Request for Tenancy Approval (RFTA)** – Documents completed by a landlord about their property. This information is sent back to a PHA so they can determine if the proposed unit can be leased up with a housing voucher.

**Rent Reasonableness (RR)** – A process designed to ensure that rents being paid are reasonable in relation to rents being charged for comparable unassisted units in the same area. This can be done by HHA or by the CM or NAV prior to submitting a rental payment.

**Scattered-Site Housing Unit** – A market rate apartment unit located throughout the CoC.

**Single Room Occupancy Unit (SRO)** – A small, furnished single apartment unit with a bed, chair, desk, microwave, & mini-fridge. The kitchen is shared and utilities are included in the rent.

**Special Populations** – specialized services for homeless youth, people living with HIV/AIDS, persons engaged in victim services programs. The term victim services means services that assist program participants who are victims of domestic violence, dating violence, sexual assault, or stalking, including services offered by rape crisis centers and domestic violence shelters, and other organizations with a documented history of effective work concerning domestic violence, dating violence, sexual assault, or stalking.

**Street Outreach** – A program designed to provide essential services necessary to reach out to unsheltered individuals experiencing homelessness by meeting individuals where they are at both physically and psychologically. Program design includes engaging and developing relationships with people experiencing homelessness in unconventional settings such as, campsites, public parks, bus/train stations, highway exit or entrance ramps, abandoned buildings, under bridges, or other places not meant for human habitation. CFR 576.101 providing essential services necessary to reach out to unsheltered homeless people; connect them with emergency shelter, housing, or critical services; and provide urgent, non-facility-based care to unsheltered homeless people who are unwilling or unable to access emergency shelter, housing, or an appropriate health facility.

Unsheltered Homeless – For the purposes of Street Outreach; An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

(i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground. CFR 576.101, CFR 576.2(1)(i)
Verification of Disability (VOD) – A document signed by a licensed practitioner that confirms that an individual has a disability that prevents the individual from working or living independently.

Verification of Homelessness (VOH) – Document(s) that confirm an individual’s homeless history.

Young Adult – Persons between the ages of 18-24