TENTATIVE UPDATES TO SYSTEM STANDARDS

These standards have not officially been adopted by our CoC. They have been developed to give providers an opportunity to see the direction our system is headed in. It's our hope that this information will help providers as they develop applications for the NOFO. There will be an opportunity for providers to give feedback on these proposed changes before they go to the Steering Committee for approval. Any new HUD guidance will impact the changes to the standards we are proposing. We aim to have updates to the system standards formally adopted by the CoC Steering Committee by February 2026.

TRANSITION HOUSING

1. Assistance Timeline
    a. Our community requires multiple pathways to stability to meet the various needs of people experiencing homelessness. Some will require long-term assistance while others require a light touch to resolve recent financial hardship. HUD allows clients in Transitional Housing (TH) to receive up to twenty-four months of assistance. Our community strategically needs projects that will serve clients in twelve- and twenty-four-month models.
        i. The twelve-month model of TH will provide rental assistance and supportive services for people experiencing homelessness during a full lease term of 12 months. Case Managers will work with clients before being housed to identify goals that will be addressed during the program to ensure there is a plan in place for stability once the project ends. There will be a standardized step-down payment scale for tenants that will require them to pay a portion of the rent.
            - Active participation in accomplishing the agreed goals will allow the provider to cover some of the client's portion of the rent. For example, if the client gains employment and maintains it during the program, covering part of the client's rental portion allows them to save money for when the project ends.
        ii. The twenty-four-month model of TH will operate very similarly to the twelve-month model. Clients referred into this model have been identified through the Coordinated Entry prioritization as possibly needing more than twelve months to reach stability. For both models, the first six months of the projects will look the same. At the seventh month mark, clients in these projects will be given the opportunity to apply for a second year of financial and supportive service assistance. In the applications, clients will discuss the goals they want to achieve during the second year and the work they are currently doing to build up to those goals.

2. Treatment Focused Projects
    a. TH projects with a focus on substance use, mental health services, and or medical care/respite are allowable. HUD is encouraging communities to leverage support from adjacent systems to build out a continuum that addresses the unique needs of our clients.
        i. Projects that are awarded a treatment focused project must adopt service and exit policies that are aligned with the system standards and must be approved by the lead agency.
            - For example, projects with a focus on sobriety/sober living/recovery, must adopt a policy to plan for what might happen if someone relapses while in the project. A relapse might occur more than once while someone is trying to maintain sobriety. With a finite number of housing projects in our system, we must make the best attempts while someone is enrolled. Exiting someone for relapsing does not help that individual get closer to their goal. Policies for this type of project around exiting clients for relapsing would need to include service agreements or activities that the client has agreed to participate in after a relapse to get back on track, before the providers consider exiting them from the program.
            - For projects that are congregate or site based, policies around exiting clients or lack of participation in service agreements should address how these decisions may impact other clients in the project and how that may impact the decision to exit someone.
        ii. HUD has not provided any eligibility guidance on drug testing or medical documentation required into treatment focused projects. Each project will need to propose policies that will be approved by the lead agency, to ensure referrals can still easily be made from Coordinated Entry to each project.
3. Eligibility
    a. Clients must have homeless verification and a referral from Coordinated Entry.
    b. Treatment focused projects will require homeless verification and a referral from Coordinated Entry; however, there may be additional referral components based on the project.
        i. The client may be required to follow additional service agreements or rules based on the tailored goals and services of the project. For example, a medical focused project may require ongoing visits with a medical care team.
4. Congregate Site/Scattered Site
    a. TH projects can be set up as a congregate site project or a scattered site project. For either project configuration, Case Management services must be primarily provided where the client lives.

PERMANENET SUPPORTIVE HOUSING (PSH)

1. To stay enrolled in a PSH project, clients will have to agree to participate in monthly Case Management services and develop a service agreement with their Case Manager.

RAPID RE-HOUSING (RRH)

1. Due to the 30% cap on how much funding is allowed to be spent on Permanent Housing (PH) projects, Rapid Re-Housing (RRH) projects and applications will be asked to convert to TH projects. PH funds will be prioritized for Permanent Supportive Housing (PSH) projects.

PSH AND RRH CONVERSION TO TH

1. While we have not received specific HUD guidance on this yet, we anticipate that PSH and RRH projects converting to TH will start following new policies and procedures with the execution of their FY25 contract.
    a. This will mean as of the contract execution date, currently enrolled clients will be eligible for twelve or twenty-four months of assistance. The timeframe of assistance offered will be dependent on whether the TH project is set up as a twelve- or twenty-four-month project.
2. Enrolled clients will have to agree to participate in monthly Case Management services and develop a service agreement with their Case Manager.

SERVICE DELIVERY REQUIREMENTS

1. Required Services
    a. Over the past year and a half, we've begun talking about the evolution of "Housing First" into the "Housing ***with*** Services" approach. Those supportive services should not be a one size fits all. It should be tailored to the unique needs of each client.
    b. Our CoC will adopt a policy that requires all clients to participate in a monthly meeting with their Case Manager.
        i. Monthly services or attempts must be documented in HMIS with the appropriate service and corresponding case note.
        ii. Monthly services should be done as a home visit within the client's residence.
        iii. If a home visit is not possible, this monthly meeting can also take place at the Case Manager's office.
        iv. If an in-person visit is not possible, a phone conversation can be scheduled.
        v. The case note that accompanies any of the service options described above should include what was discussed, next steps, and if applicable, why the meeting was not in person or at the client's residence.

c. Clients will also be required to develop a service agreement with their Case Manager. The service agreement will outline goals that the client would like to accomplish while enrolled in the program that will aid in their stabilization. The goal categories will have a wide range. Some of those categories may include increasing income, building connections to community resources, health and wellness, or repairing relationships. All of these could improve someone's ability to avoid homelessness in the future.
d. After collecting community feedback, CFTH will present the Steering Committee with a service agreement for projects to utilize, along with the updates to the standards.
    i. The standards will include information on how these agreements and services need to be documented in HMIS.

2. HUD has put out some initial guidance that TH service providers should aim to offer directly or connect clients to 40 hours of service activities each week. There is no clear guidance on how many of those services clients must participate in to remain eligible for the program.
    a. The service agreement clients and Case Managers work on together must reflect the services the provider offers or connects them to. However, the agreement can always be amended to address new interests the client has.
    b. While it is still to be determined, it is likely that services in HMIS will be utilized to track the level of engagement a client has in various services that are outlined in the agreement.