BOARD OF SUPERVISORS AGENDA ITEM REPORT
AWARDS / CONTRACTS / GRANTS

○ Award ◉ Contract ○ Grant

Requested Board Meeting Date: 11/15/2022

* = *Mandatory, information must be provided*

or Procurement Director Award: ☐

***Contractor/Vendor Name/Grantor (DBA):**

Salvation Army

***Project Title/Description:**

United States Housing and Urban Development Continuum of Care Program - Project Advent

***Purpose:**

United States Housing and Urban Development (USHUD) has awarded Continuum of Care Project Advent Program funds to the County for services to the homeless. Salvation Army, a subrecipient, will provide case management and financial assistance to obtain Rapid Rehousing for homeless individuals and families and to help these program participants overcome barriers to acquiring and maintaining permanent housing. A standardized referral process is used to match participants to the Pima County Sullivan Jackson Employment Center (SJEC). Program participants then enter Rapid Rehousing through Salvation Army. Once housing is stabilized, Salvation Army case managers work with participants to place them into housing. SJEC then begins to work with participants to obtain full-time employment. After clients find work, they begin to contribute toward the rent with the goal of becoming self-sufficient within six months. This amendment will provide additional funding for the period of July 1, 2022 to June 30, 2023.

Attachment: Contract Number CT-CR-21-418 (Amendment 01)

***Procurement Method:**

This Subrecipient Agreement is a non-Procurement contract and not subject to Procurement rules.

***Program Goals/Predicted Outcomes:**

Subrecipient will maintain a minimum of 15 units filled at any given time (1 unit is considered 1 individual or family).

***Public Benefit:**

Supports economic development by helping to develop a trained and productive labor force and reduce homelessness in Pima County.

***Metrics Available to Measure Performance:**

The program performance will be tracked in the Homeless Management Information System (HMIS) or a comparable database.

***Retroactive:**

Yes. The county received the Grant Agreement from USHUD on July 6, 2022. The subrecipient agreement could not be processed until the Project Advent grant was approved by the Board. The grant was approved at the August 15, 2022 Board of Supervisors' meeting. In addition to the delay from USHUD for the grant renewal, the subrecipient was not timely with signing and returning the amendment. On August 9, the amendment was sent to Salvation Army (SA); however budget revisions were required. Budget revisions were sent to SA on September 9 and September 23. SA approved the amendment on October 6. Community & Workforce Development Department received the signed amendment on October 14. The negative impact of not approving this amendment is Pima County homeless may not receive funds for rental assistance.

TO: COB 11-1-2022
Vers.: 5
Pgs.: 26

6 DI apprvs
10/31/22

NOV01'22AM1046PD

THE APPLICABLE SECTION(S) BELOW MUST BE COMPLETED

Click or tap the boxes to enter text. If not applicable, indicate "N/A". Make sure to complete mandatory (*) fields

Contract / Award Information

Document Type: _____ Department Code: _____ Contract Number (i.e., 15-123): _____

Commencement Date: _____ Termination Date: _____ Prior Contract Number (Synergen/CMS): _____

☐ Expense Amount $ _____* ☐ Revenue Amount: $ _____

***Funding Source(s) required:** _____

Funding from General Fund? ○ Yes ○ No If Yes $ _____ % _____

Contract is fully or partially funded with Federal Funds? ○ Yes ○ No

If Yes, is the Contract to a vendor or subrecipient? _____

Were insurance or indemnity clauses modified? ○ Yes ○ No

If Yes, attach Risk's approval.

Vendor is using a Social Security Number? ○ Yes ◉ No

If Yes, attach the required form per Administrative Procedure 22-10.

Amendment / Revised Award Information

Document Type: CT Department Code: CR Contract Number (i.e., 15-123): 21-418

Amendment No.: 1 AMS Version No.: 5

Commencement Date: 7/1/22 New Termination Date: 6/30/23

Prior Contract No. (Synergen/CMS): NA

◉ Expense ○ Revenue ◉ Increase ○ Decrease Amount This Amendment: $ 142,497.50

Is there revenue included? ○ Yes ◉ No If Yes $ _____

***Funding Source(s) required: United States Housing and Urban Development-Continuum of Care (CoC) Program**

Funding from General Fund? ○ Yes ◉ No If Yes $ _____ % _____

Grant/Amendment Information (for grants acceptance and awards) ○ Award ○ Amendment

Document Type: _____ Department Code: _____ Grant Number (i.e., 15-123): _____

Commencement Date: _____ Termination Date: _____ Amendment Number: _____

☐ Match Amount: $ _____ ☐ Revenue Amount: $ _____

***All Funding Source(s) required:** _____

***Match funding from General Fund?** ○ Yes ○ No If Yes $ _____ % _____

***Match funding from other sources?** ○ Yes ○ No If Yes $ _____ % _____

***Funding Source:** _____

***If Federal funds are received, is funding coming directly from the Federal government or passed through other organization(s)?**

_____

Contact: Rise Hart

Department: Community & Workforce Development Telephone: 724-5723

Department Director Signature: Daniel P. Sayler Date: 10/17/2022

Deputy County Administrator Signature: _____ Date: 31 Oct 2022

County Administrator Signature: _____ Date: 10/31/2022

PIMA COUNTY COMMUNITY & WORKFORCE DEVELOPMENT DEPARTMENT – Sullivan Jackson Employment Center

Project: United States Housing and Urban Development Continuum of Care Program – Project Advent

Subrecipient: Salvation Army
1001 North Richey Blvd.
Tucson, AZ 85716

Contract No.: CT-CR-21-418

Contract Amendment No.: 01

Original Contract Term:	07/01/21 – 06/30/22	Orig. Contract Amount:	$154,474.50
Termination Date Prior Amendment:	N/A	Prior Amendments Amount:	N/A
Termination Date This Amendment:	06/30/23	This Amendment Amount:	$142,497.50
		Revised Total Amount:	$296,972.00

Unique Entity Identifier: WKZ9BWP1U5L3		**SAM Registration Date:** 5/29/2021			
Research or Development:		☐ Yes ☒ No			
Federal Contract No: AZ0042L9T012114			**Award Date:**	2022	
Required Match:	☒ Yes ☐ No	**Match Amount:**	25%		
Indirect Cost Rate:	☐	☒ NICR	☐ de minimis	☐ None	
Status of Contractor:		☒ Subrecipient	☐ Contractor		

CFDA	Grant Program	National Funding	Pima County Award
14.267	Continuum of Care Homeless Program ("CoC") – Project Advent	$2,500,000,000.00	$451,001.00

GRANT FUNDING AGREEMENT – AMENDMENT ONE

1. **BACKGROUND AND PURPOSE.**

   1.1. **Background.** On July 6, 2021, County and Salvation Army ("Subrecipient"), entered into the above-referenced Agreement to provide case management and financial assistance to obtain rapid rehousing for homeless individuals and families and to help program participants overcome barriers to acquiring and maintaining permanent housing.

   1.2. **Purpose.** As a Subrecipient of U.S. Department of Housing and Urban Development ("HUD") Project Advent funds, Subrecipient will conduct all activities under this Agreement accordingly. County finds that it is in the best interests of the residents of Pima County to provide an additional year of housing and support services for the homeless.

2. **TERM AND EXTENSIONS, SECTION 2.** Pursuant to Paragraph 2.1, County exercises the first of four extension options. The commencement date for Amendment No. 1 is July 1, 2022. This Amendment will terminate on June 30, 2023.

3. **COMPENSATION AND PAYMENT, SECTION 5.** Paragraph 5.1 is amended to increase "the Maximum Allocated Amount" from $154,474.50 to $296,972.00. The rest of Paragraph 5.1 remains the same.

4. **EXHIBIT A – SCOPE OF WORK** is deleted in its entirety and replaced with a revised Exhibit A-1 attached to this Amendment.

5. **EXHIBIT B – TUCSON PIMA COLLABORATION TO END HOMELESSNESS COC PROGRAM WRITTEN STANDARDS** is deleted in its entirety and replaced with a revised Exhibit B-1 attached to this Amendment.

6. **EXHIBIT C – MEMORANDUM OF UNDERSTANDING IN THE PIMA COUNTY COMMUNITY SERVICES DEPARTMENT SULLIVAN JACKSON EMPLOYMENT CENTER JOB OFFER ACADEMY AND ENROLLED PROGRAM PARTICIPANT** is deleted in its entirety and replaced with a revised Exhibit C-1 attached to this Amendment.

SIGNATURE PAGE TO FOLLOW

All other provisions of this Agreement, not specifically changed by this amendment, will remain in effect and be binding upon the parties.

IN WITNESS WHEREOF, the parties do hereby affix their signatures and do hereby agree to carry out the terms of this Amendment and of the original Contract cited herein:

PIMA COUNTY:

Sharon Bronson, Chair
Pima County Board of Supervisors

Date

ATTEST:

Clerk of the Board Date

APPROVED AS TO CONTENT:

Director, Community & Workforce Development

APPROVED AS TO FORM:

Deputy County Attorney

SUBRECIPIENT:

Authorized Signature

MICHAEL ZIELINSKI ASSISTANT TREASURER

MICHAEL ZIELINSKI
Printed Name & Title

Date: 10/6/22

1. **PROGRAM OVERVIEW.** Subrecipient will provide case management and financial assistance to obtain Rapid Rehousing ("RRH") for homeless individuals and families and to help these program participants overcome barriers to acquiring and maintaining permanent housing. Program participants must be homeless, as defined by the U.S. Department of Housing and Urban Development ("HUD"), at the time of referral for services.

2. **PROJECT ACTIVITIES - SUBRECIPIENT.**

2.1. Case Management.

2.1.1. Subrecipient shall ensure that all case management activities are provided in accordance with 24 CFR § 578.53(3). In addition, Subrecipient shall comply with the Tucson Pima Collaboration to End Homelessness CoC Program Written Standards established by the CoC ("the written standards") attached as Exhibit B-1(19 pages). Subrecipient shall also comply with the Fair Housing Act.

2.1.2. Subrecipient shall employ at least one FTE qualified case manager to provide services under this Agreement. Each case manager will within 48 hours of referral, assess individual and household needs of the program participant.

2.1.3. The case manager will work with each program participant to develop the following:

2.1.3.1. A case plan that must include clearly defined goals and outcomes focusing on achieving permanent employment and self-sufficiency.

2.1.3.2. A housing plan that must map out a path to permanent housing stability.

2.1.3.3. A realistic household budget, that includes a savings plan, to ensure that the participant can maintain permanent housing after completing the program.

2.1.4. The case manager will help arrange and coordinate access to necessary resources to support the goals and objectives identified in the case and housing plans and the budget. The case manager must also meet with program participants a minimum of twice per month to monitor and evaluate progress towards the goals and outcomes in the case plan and adjust plan goals as warranted to ensure success. After the program participant is placed in housing, these meetings must occur at the program participant's home.

2.1.5. The case manager will enter program participant's housed (move-in) date information into the Homeless Management Information System ("HMIS") and any other databases specified by County within two business days of an activities occurring. Any and all changes that occur during the program participants stay must be reported to Sullivan Jackson Workforce Development Specialist ("WDS") within two business days so the information can be updated into the HMIS system. Those activities include but are not limited to: income change, non-cash benefits change, health insurance change, family changes (children entering/leaving household or spouse leaving household). Communication when a participant will be exited from the program must be discussed between both WDS and subrecipient. The case manager must also complete a Full Service Prioritization Decision Assistance Tool ("SPDAT") upon each participant's entry into housing and every 90 days thereafter until the program participant exists the program.

2.1.6. Subrecipient shall reimburse case managers for the following:

2.1.6.1. Mileage, at approved county rate, for visiting and monitoring program participants.

2.1.6.2. Costs associated with accompanying program participants on public transportation.

2.2. Housing Assistance. Subrecipient shall provide housing assistance in the selection of RRH to the number of program participants in paragraph 5.2. RRH selected must be appropriate to the program participant's household size, needs, and potential earned income. Subrecipient must move each household into appropriate housing within 30 days from the date of the assessment conducted or contact County if needing extended time to locate housing.

2.3. Subrecipient's housing assistance activities will include, but are not limited to, the following:

2.3.1. After housing is selected, inspect housing for compliance with the applicable housing quality standards (HQS) in 24 CFR § 982.401 and, while the program participant resides in the housing, re-inspect for HQS compliance annually.

2.3.2. Ensure that program participant enters into a lease agreement with the landlord. The initial term of the lease must be for at least (12) twelve month and shall be automatically renewable upon expiration, except on prior notice by either party, up to a maximum of 24 months.

2.2.3. Pursuant to the written standards, calculate each program participant's contribution to housing costs ("resident rent") and insure that participant pays rent monthly. Rental payments by program participants are not to be considered "match" with regards to the cash match requirements of Continuum of Care (CoC) programs.

2.2.4. Pay rent directly to landlord for portion of the rent that the program participant is not required to pay. Rental payments by program participants paid directly to the landlord are not to be considered "match" with regards to the cash match requirements of CoC programs.

2.4. Transportation. To ensure access to education, employment and/or health care services, Subrecipient shall provide participants with bus passes or taxi or livery services (only in the event public transportation is not available).

2.5. Other financial Supportive Service. When necessary, Subrecipient will pay on behalf of the participant utility deposits and/or one-time moving costs, including truck rental and hiring of a moving company. Support services that are eligible are found under CFR 578.53.

3. PROGRAM ACTIVITIES - COUNTY. County will determine eligibility of individuals and households seeking CoC services. Based on the information available in the Pima County Coordinated Entry System, County will refer eligible individuals or households, as appropriate, to Suhrecipient for Advent services. County will also Enroll participants it determines eligible into the Continuum of Care Program established pursuant to 24 CFR Part 578. County in collaboration with Subricipent will also provide, or arrange for, education services, employment assistance and job training, and life skills training as determined necessary and appropriate for each participant.

4. PROGRAM ACTIVITIES - SUBRECIPIENT and COUNTY.

4.1. Subrecipient and County will refer individuals and/or families to Pima County Sullivan Jackson Employment Center ("SJEC") for eligibility determination and enrollment into appropriate programs and services.

4.2. Subrecipient and County will meet at least once each month to review and evaluate each participant's case plan and progress towards achieving the goals and outcomes; coordinate resources being offered to each participant; avoid duplication of service; and provide information and referrals to other service providers.

5. PROJECT GOAL/PREDICTED OUTCOMES.

5.1. Subrecipient will provide RRH, case management and associated services.

5.2. Subrecipient will maintain a minimum of 15 units filled at any given time (1 unit is considered 1 individual or family)

5.3. Subrecipient shall meet the Community Performance Standards as Exhibit C-1 (1 page).

5.4. Participants shall have an economic plan and a plan for Housing Stability as follows:

Of total participants severed	Achievement - Eligible program participants
100%	Develop a realistic budget based upon household income
80%	Establish and maintain a savings account with a balance consistent with their case plan objectives
80%	Secure all non-cash benefits for which they are eligible
100%	Participate in developing and revising their case plans throughout the time participating in the program
80%	Move into permanent, unsubsidized housing after completing and exiting the program

6. BUDGET.

6.1. For services provided July 1, 2022 through June 30, 2023, County will pay Subrecipient as follows:

BUDGET LINE ITEM	**AMOUNT**
Rental Assistance	$96,671.00
Case Management (Personnel and Fringe)	$34,686.36
Participant Supportive Services (Move-in Costs, Transportation, and Utility Deposits)	$1,000.00
Direct Administrative Costs (Personnel and Fringe)	$6,065.00
Total Direct Costs	*$138,422.36*
Indirect Costs	*$4,075.14*
Total Program Budget	**$142,497.50**

6.2. Subrecipient has a Negotiated Indirect Cost Rate Agreement (NICRA) of 25.5%; however, chooses to claim 10% of personnel and fringe.

6.3. Subrecipient shall provide funds to match up to 25% based on eligible program costs subject to contract modifications. Additional conditions include, but are not limited to:

6.3.1. Matching funds shall comply with 24 CFR § 578.73.

6.3.2. Funds used to match a previous CoC grant may not be used to match a subsequent grant award.

6.3.3. Funds from other federal grants can be used as match.

6.3.4. Subrecipient must provide a list of matching funds to County with each draw-down of CoC funds.

7. REPORTING. Subrecipient shall:

7.1. Provide monthly reports on program activities.

7.2. Provide an Annual Report per HUD requirements for each fiscal year.

7.3. Record all participants' move-in date data in HMIS under Enter Data As ("EDA").

7.4. Ensure that all invoiced participants are in HMIS in the appropriate program.

END OF EXHIBIT A-1

TUCSON PIMA COLLABORATION TO END HOMELESSNESS COC PROGRAM WRITTEN STANDARDS
Adopted April 28, 2015, Amended Jan. 26, 2016, June 28, 2016 and May 11, 2017; Dec. 18, 2018; Feb. 26, 2019; June 26, 2019; August 27, 2019; January 12, 2021

INTRODUCTION & PURPOSE

Tucson Pima Collaboration to End Homelessness (TPCH) has established written standards that encompass local community needs and follow guidelines set forth by the Department Housing and Urban Development (HUD) and comply with requirements established by law and HUD Notice. These written standards are developed to ensure people within this community who are experiencing homelessness are prioritized and provided with the most appropriate housing and services to meet their needs.

These written standards are reviewed and adjusted at least annually. Changes to priorities may supersede this notice if voted on by the TPCH Board of Directors (for example; a surge in prioritizing veterans). Further requirements are detailed in TPCH Policy and Procedure documents.

These written standards are developed in coordination with recipients of Emergency Solutions Grants program funds to achieve the following:

- Create and maintain a centralized or coordinated entry system that provides an initial, comprehensive assessment of the needs of families and individuals for housing and services
- Policies and procedures for evaluating individuals' and families' eligibility for assistance under this part.
- Policies and procedures for determining and prioritizing which eligible families and individuals will receive transitional housing assistance.
- Policies and procedures for determining and prioritizing which eligible families and individuals will receive rapid rehousing assistance.
- Standards for determining what percentage or amount of rent each program participant must pay while receiving rapid rehousing assistance.
- Policies and procedures for determining and prioritizing which eligible families and individuals will receive permanent supportive housing assistance

KEY TERMS

Beds

A bed is each assigned spot in a housing program for a person; not literally a bed. If there are three people in a household, regardless of their sleeping arrangements, the household has three beds.

Client-Centered

Client-centered (or person-centered) services are designed and delivered based on the specific needs and wants of each family or individual as they perceive those needs and wants rather than as required or delivered by the service provider based on a schedule, program participation, or the providers' perception. A client-centered service delivery process involves mutual discussion and decision-making on what steps are needed for client stability and when and how to take those steps. For example, client-centered service could include, but not be limited to, determining a family's preferences and helping them find housing that is not just to their needs and liking, but also near a particular school.

Chronically Homeless

An individual or family is chronically homeless when the person or head of household (adult or minor) meets all three criteria established as the final rule for 24 CRF Parts 91 and 578 as amended December 4, 2015. The three criteria are that the person/family:

- Has a qualifying disability (a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability)
- Is literally homeless (at the time of eligibility assessment for a specific project opening)
- Has at least 12 months of homelessness from one of the below avenues:
    - The current episode of homeless has lasted at lasted the past 365 nights, including the night before assessment, without breaks in homelessness.
    - Having four episodes, or more, of homelessness within the past three years up to and including the date of assessment. These episodes, when added together, total 365 nights or more of literal homelessness. Also, each break in homelessness must have lasted at least seven (7) consecutive nights.
    - Both the cumulative nights and four or greater episodes criteria must be met. Fewer than four episodes in three years – even if homeless nights add up to 12 or more months – will not qualify the person/family as chronically homeless. Greater than four episodes in three years will not suffice if the total nights homeless are under 365.

Equal Access:

This community provides equal access to all programs and activities, regardless of (actual or perceived) sexual orientation, gender identity, marital status, race, color, national origin, religion, sex, familial status, disability, or any other protected class as identified by Federal or Local law.

This community houses people based on the gender they identify as, without requesting documentation to validate their report. This community recognizes the HUD Final Rule and all amendments published 2/3/2012, 9/21/16 and the Notice on Equal Access Regardless of Sexual Orientation, Gender Identity, or Marital Status for HUD's CPD Programs.

Gender Identity

This is defined as a person's concept of oneself as male, female, both or neither. Gender identity may or may not align with the "sex" or "gender" described on an individual's birth certificate or other identity documents.

Homeless

HUD classifies homelessness into categories, or levels, of homelessness. These include literally homeless, imminent risk of homelessness and chronically homeless and are detailed in the Evaluating and Documenting Eligibility (Categories of Homelessness & Required Types of Verification) section of this document.

Unsheltered: People are considered homeless, and unsheltered, when they are living in places not meant for human habitation.

Sheltered: People are considered homeless, yet sheltered, when they are staying in places meant for human habitation, emergency shelters, transitional housing, or facing imminent homelessness.

Housing First

Housing First is an approach in which housing is offered to people experiencing homelessness without preconditions (such as sobriety, mental health treatment, or a minimum income threshold) or service participation requirements. Rapid placement and stabilization in permanent housing are primary goals. Service participation is not required for continued tenancy. Projects that use a Housing First approach promote the acceptance of applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services, yet offer assertive engagement in support and treatment options to the participants who are housed.

LGBTQ

This is an acronym for "lesbian, gay, bisexual, transgender or transsexual, questioning or queer." It is intended to emphasize a diversity of sexuality and gender identities, including identities that do not fall within the binary of "male" and "female," and may be used to refer to anyone who self-identifies as non-heterosexual.

Permanent Supportive Housing (PSH)

Permanent Supportive Housing is rental assistance with supportive services without a designated length of stay to assist homeless persons with a disability to live independently and achieve housing stability.

Rapid Rehousing (RRH)

Rapid Rehousing Assistance is client-centered housing relocation and stabilization services with short and/or long-term rental assistance. RRH helps an individual or family move as quickly as possible into permanent housing and achieve stability in that housing.

Safe Haven

A Safe Haven is a temporary supportive housing program that serves hard-to-reach literally homeless persons with severe mental illness who come primarily from the streets and have been unable or unwilling to participate in housing or supportive services. These facilities allow 24-hour residence for an unspecified duration, have private or semi-private accommodations, and provide access to needed, but not required, services in a low demand facility.

Severity of Service Needs

TPCH classifies service needs into four categories; Severe, High, Moderate and Low. Families and Individuals are classified via the SPDAT score indicates which level of service needs the individual or family will be classified as.

	VI SPDAT			Full SPDAT	
	Individuals	Youth	Families	Individuals/Youth	Families
Severe Service Needs	12-17	12-17	12-22	45-60	66-80
High Service Needs	8-11	8-11	9-11	35-44	54-65
Moderate Service Needs	4-7	4-7	4-8	20-34	27-53
Low Service Needs	0-3	0-3	0-3	0-19	0-26

An individual or family is considered to have a high severity of services needs when at least one of the following is true:

i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; or
ii. Significant health or behavioral health challenges or functional impairments which require a significant level or support in order to maintain permanent housing.
iii. For youth and victims of domestic violence, there is a high risk of continued trauma or high risk of harm or exposure to very dangerous living situations.
iv. When applicable CoC Program-funded PSH may use alternate criteria used by state Medicaid departments to identify high-need, high-cost beneficiaries.

The determination is not to be based on a specific diagnosis or disability type. The determination will not be based on any factors that would result in a violation of any nondiscrimination and equal opportunity requirements. (See 24 CRF § 5.105 (a).)

Families and individuals with low service needs will not be served in CoC-funded projects.

SPDAT (Service Prioritization Decision Assistance Tool)

The SPDAT portfolio consists of evidence-based, standardized assessment tools that allow providers to effectively assess the severity of service needs for people experiencing homelessness. TPCH utilizes SPDAT scores for prioritization of families and individuals for housing resources. The Vulnerability Index (VI) SPDAT is utilized for pre-screening families, individuals, and youth. The Full SPDAT assessment also has versions for these populations. These SPDATs are more in-depth assessments and case management tools.

Transitional Housing (TH)

Transitional housing provides homeless families and individuals with the interim stability and support to successfully move to and maintain permanent housing. Homeless persons may live in transitional housing for up to 24 months and receive support services that help them live more independently.

TPCH

Tucson Pima Collaboration to End Homelessness (TPCH) is a coalition of community and faith-based organizations, government entities, businesses, and individuals committed to the mission of ending homelessness, advocating for and addressing the issues related to homelessness in our community, and acting as the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) for the geographic area of Tucson and Pima County, Arizona.

Victim Service Provider

A victim service provider is an organization whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, stalking or human trafficking.

GENERAL POLICIES

Family Admission and Non-Separation
Ensuring Educational Rights
Persons Fleeing Domestic Violence
Persons Identifying as LGBTQ
Housing First

Family Admission and Non-Separation

Consistent with the CoC Program Interim Rule 578.93, neither CoC nor ESG program-funded grant recipients and subrecipients may involuntarily separate families. The age and gender of a child under age 18 will not be used as a basis for denying any family's admission to a project that receives CoC or ESG funds. The gender, sexual orientation and/or marital status of a parent or parents will also not be used as a basis for denying any family's admission to a project that receives CoC or ESG funds.

The CoC will work closely with providers to ensure that placement efforts are coordinated to avoid involuntary family separation, including referring clients for the most appropriate services and housing to match their needs.
Any client who believes that they or a family member has experienced involuntary separation may report the issue to the CoC through www.tpch.net and "Contact TPCH". The CoC will investigate the claim and take appropriate remedial action.

Ensuring Educational Rights

Consistent with the CoC Program Interim Rule 578.23 and 578.93 (e), all CoC and ESG program funded recipients and subrecipients assisting families with children or unaccompanied youth must:

1. Take into account the educational needs of children when placing families in housing and will, to the maximum extent practicable, place families with children as close as possible to their school of origin so as not to disrupt such children's education.
2. Inform families with children and unaccompanied youth of their educational rights, including providing written materials, provide linkage to McKinney Vento Liaisons (including assistance with enrollment if needed) as part of intake procedures.
3. Not require children and unaccompanied youth to enroll in a new school as a condition of receiving services.
4. Allow parents or the youth (if unaccompanied) to make decisions about school placement.
5. Not require children and unaccompanied youth to attend after-school or educational programs that would replace/interfere with regular day school or prohibit them from staying enrolled in their original school.
6. Post notices of educational rights at each program site that serves homeless children and families in appropriate languages.
7. Designate a staff member who will be responsible for:
    a. ensuring that homeless children and youth in their programs are in school and are receiving all educational services to which they are entitled.
    b. coordinating with the local McKinney Vento Educational Coordinator and Liaison, the appropriate school district, the CoC, and other mainstream providers as needed.
    c. facilitating unaccompanied youth who have not obtained a high school diploma or certificate of General Educational Development (GED) to obtain such a credential and ensuring that unaccompanied youth are connected to appropriate services in the community.

Clients who believe that their educational rights have not been observed may report the issue to the CoC through www.tpch.net and "Contact TPCH".

Persons Fleeing Domestic Violence

Consistent with the CoC Program Interim Rule 24 CFR Part 578.5 (8), all CoC program funding recipients and subrecipients will provide safe, confidential and equal access to TPCH's "no wrong door" coordinated entry process and referrals to either domestic violence service providers or CoC or ESG funded project recipients and subrecipients for families and individuals

who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking regardless of whether or not they consent to share their data through the HMIS.

The CoC will work closely with ESG and domestic violence service providers to ensure that any individual or family fleeing as described above will have the opportunity through coordinated entry and in accordance with the CoC's Coordinated Entry Policies and Procedures to be safely, confidentially and immediately transferred to a domestic violence services provider, if desired. While domestic violence service providers do not participate in the TPCH HMIS, these providers are encouraged to obtain from their clients consent for confidential staffing (using de-identified data) and referral to housing and services from other providers through the coordinated entry as desired and needed by clients. If individuals or families fleeing domestic violence do not desire such a transfer, they may be assessed and/or undergo intake through the normal coordinated entry system.

All CoC grant recipients and subrecipients within the CoC geographic area will make all efforts to: protect the privacy and safety of domestic violence survivor; uphold client choice by presenting a range of housing and service options; and ensure that housing, once established, is not endangered because of reports of domestic violence or re-victimization. TPCH will offer staff training on dealing with those fleeing domestic violence and/or trauma informed care no less than annually.
In compliance with under §578.51 (c)(3), any program participants who have complied with all program requirements during their residence and who have been a victim of domestic violence, dating violence, sexual assault, or stalking, and who reasonably believe they are imminently threatened by harm from further domestic violence, dating violence, sexual assault, or stalking (which would include threats from a third party, such as a friend or family member of the perpetrator of the violence), if they remain in the assisted unit, and are able to document the violence and basis for their belief, may retain the rental assistance and may move to a different CoC geographic area if they move out of the assisted unit to protect their health and safety and the CoC to which they are moving did not participate in the decision to move.

For each program participant who elects to move to a different CoC due to imminent threat of further violence under §578.51 (c) (3), the CoC project in which they participated must retain:

1. Documentation of the original incidence of violence.
2. Documentation of the reasonable belief of imminent threat of further violence. This would include threats from a third party, such as a friend or family member of the perpetrator of the violence.

In either case, the documentation may be the housing or service provider's written observation; a letter or other documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider or other professional from whom the victim has sought assistance; medical or dental records; court or law enforcement records; or written certification by the program participant to whom the violence occurred or by the head of household.

Persons Identifying as LGBTQ

Consistent with the CoC Program Interim Rule 578.93 (a), final rule 77 FR 21 5662 and CPD-15-02, all CoC recipients and subrecipients will make available their housing and services to families and individuals without regard to actual or perceived sexual orientation, gender identity (whether actual or perceived gender-related characteristics), or marital status. In addition, CoC and ESG program funded recipients and subrecipients will:

1. Recognize that biological sex as reported at birth may not correspond to an individual's gender identity, ask about gender identity or sexual orientation to determine eligibility if the facility to which the individual client seeks admission has shared sleeping areas or bathrooms, or to determine the number of bedrooms to which a household may be entitled.
2. Provide access to shelter and housing programs based on a person's self-identified gender, taking health and safety, and non-binary gender identity concerns into consideration.
3. Neither request documentation of a person's sex, anatomy or medical history in order to determine appropriate placement nor deny access to a single-sex emergency shelter or facility solely because the individual's identity documents indicate a sex different than the gender with which the client or potential client identifies or because his or her appearance or behavior does not conform to gender stereotypes; nor consider a person ineligible for any facility

based on the factors outlined above.

4. Maintain the confidentiality of any individual's disclosure regarding their sexual orientation or gender identity; notify persons who identify as LBGTQ when and to whom that identification may be shared during referrals; and, during intake, inquire about a client's preference regarding the disclosure or non-disclosure to some or all staff of their stated orientation and/or gender identity, and then abide by that preference.
5. Neither isolate nor segregate a client based on gender identity unless by that client's request or for that client's safety. HUD assumes that a provider will not make an assignment or re-assignment based on complaints of another person when the sole stated basis of the complaint is a client or potential client's non-conformance with gender stereotypes.
6. Take reasonable steps to address any concerns expressed by a client or observed by a provider regarding safety or privacy. Whenever physically possible, providers will ensure that toilet stalls have doors and locks and that separate shower stalls are available. When these physical amenities are not available, providers will work with individuals (to the extent possible within the physical layout of their facility) to provide accommodations such as: addition of a privacy partition or curtain; use of a nearby private restroom or office; or a separate changing schedule.
7. Ensure that all recipient and subrecipient staff members and contractors who interact directly with potential and current clients are aware of these rules and guidelines through at least annual training, and take prompt corrective action to address noncompliance as reported through www.tpch.net and "Contact TPCH".

Housing First

These Written Standards establish that all Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH) Projects adopt the Housing First model.

Housing First is an approach to quickly and successfully connect families and individuals to permanent housing. Housing First programs do not create barriers to entry such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness.

Housing First considers all participants as "housing ready" vs only those participants that have completed treatment or achieved sobriety. There are no programmatic prerequisites to program entry such as minimum income, sobriety or treatment requirements. Programs fill their vacancies with households selected through the Coordinated Entry process.

All attempts are made to streamline the move-in process by aiding households with the eligibility process and by obtaining documents per the HUD regulations, which provide a grace period for obtaining chronic homeless documentation when it cannot be obtained at the time of housing offer of move-in. (See Timelines for Obtaining Documentation of Chronic Homelessness) This community's Housing First programs do not require chronic homeless documentation prior to program entry.

Housing First programs recognize tenant rights, responsibilities, and legal protections. Programs educate participants on these topics such as lease terms and Fair Housing. Program managers abide by these laws; projects respect tenant rights while providing services.

Housing First programs seek to maintain housing for participants through practices that provide services to build skills and seek leniency whenever possible. For example, the program will offer budgeting classes and seek a payment plan instead of seeking eviction for a participant failing to pay his or her rent.

Supportive services support recovery while respecting client choice. Participants are not forced into treatment but are continually offered a wide array of services and supports understanding that participants may decline them. There are no penalties for declining services within Housing first programs.

PERFORMANCE STANDARDS

TPCH requires that CoC Grant Recipients meet the following benchmarks for grants and financial management that communities must reach to meet this Standard of Recipient Performance. (Per 24 CFR 578 and the FY2015 NOFA). TPCH requires that all projects:

1. Partner with established integrated health care relationships to ensure coverage for all participants.
2. Partner with employment resources to ensure participants have access to job training and development resources as needed.
3. Work closely with participants to access all mainstream benefits for which they are eligible.
4. Submit Annual Performance Reports by the deadline.
5. Avoid or resolve HUD monitoring findings, or OIG Audits, if applicable.
6. Maintain quarterly drawdowns.
7. Fully expend awarded funds.
8. Maintain full and high-quality participation in the TPCH HMIS.
9. Maintain full and high-quality participation in the TPCH Coordinated Entry system.

TPCH further requires that all CoC Grant Recipients meet the following standards according to the type of project being administered.

PERFORMANCE STANDARDS FOR SAFE HAVEN PROJECTS

Measure	High-Performing	Performing	Low-Performing
Housing First Approach	100%	100%	< 100%
Grant Expenditure	100%	≥ 90%	≤ 89%
Bed Utilization Rate	≥ 95%	79-94%	≤78%
Residential Stayers with Income (High performance at 80% of PSH standard)	≥ 40%	31-39%	≤30%
Residential Stayers with Increased Income (High performance at 70% of PSH standard)	≥ 35%	26-31%	≤25%
Residential Stayers with Non-Cash Benefits	≥ 75%	51-74%	≤50%
Residential Leavers with Income (Matches PSH standard)	≥ 40%	21-39%	≤20%
Residential Leavers with Increased Income (High Performance at ~10% less than High Performance for Residential Leavers with Income)	≥ 35%	21-34%	≤20%
Residential Leavers with Non-Cash Benefits (Matches PSH standard)	≥ 50%	41-49%	≤40%
Residential Exits to Permanent Housing (High Performance at 90% of PSH standard)	≥ 86%	80-85%	≤79%
All Stayers with Income	≥ 25%	21-24%	≤20%
All Stayers with Increased Income	≥ 25%	21-24%	≤20%
All Stayers with Non-Cash Benefits	≥ 50%	30-49%	≤29%
All Leavers with Income	≥ 25%	21-24%	≤20%
All Leavers with Increased Income	≥ 25%	21-24%	≤20%
All Leavers with Non-Cash Benefits	≥ 50%	30-49%	≤29%
All Exits to Permanent Housing (Matches ESG Street Outreach standard)	≥ 65%	35-64%	≤34%

PERFORMANCE STANDARDS FOR TH, TH-RRH, AND RRH PROJECTS

Measure	High-Performing	Performing	Low-Performing
Housing First Approach	100%	100%	< 100%
Accepted Referrals from Coordinated Entry	100%	90-99%	≤ 89%
Grant Expenditure	100%	≥ 90%	≤ 89%
Bed Utilization Rate	100%	≥ 90%	≤89%
Leavers with Income	≥ 75%	51-74%	≤ 50%
Leavers who Increased Income	≥ 50%	21-49%	≤ 20%
Exits to PH	≥ 96%	91-95%	≤ 90%
Data Quality	≥ 96%	95-90%	≤ 89%

PERFORMANCE STANDARDS FOR PSH PROJECTS

Measure	High-Performing	Performing	Low-Performing
Housing First Approach	100%	100%	< 100%
Coordinated Entry Participation	100%	99-90%	≤ 89%
Grant Expenditure	100%	99-90%	≤ 89%
Bed Utilization Rate	≥ 95%	94 - 79%	≤ 78%
Meeting contract goals	100%	99-95%	≤ 94%
Stayers with income	≥ 50%	49 – 41%	≤ 40%
Stayers who Increased Income	≥ 50%	49 – 41%	≤ 40%
Stayers with non-cash benefits	≥ 75%	74% - 51%	≤ 50%
Leavers with Income	≥ 40%	39 - 21%	≤ 20%
Leavers who Increased Income	≥ 40%	39 - 21%	≤ 20%
Leavers with non-cash benefits	≥ 50%	49 - 41%	≤ 40%
Exits to PH	≥ 96%	95 - 91%	≤ 90%

PRIORITIZATION FOR HUD-VASH HOUSING

1. Chronically homeless Veterans will be given the highest priority for admission.
2. Admission decisions are to be prioritized by highest need for HUD-VASH, BASED ON Veteran's acuity per clinical judgment and resources availability.
3. Where there are no chronically homeless Veterans, admissions to HUD-VASH will use the HUD Notice CPD-16-11, *Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing,* in the following order of priority:
   a) **First Priority.** Homeless persons with a disability with long periods of episodic homelessness and severe service needs.
   b) **Second Priority.** Homeless persons with a disability with severe service needs.
   c) **Third Priority.** Homeless persons with a disability coming from places not meant for human habitation, safe havens, or emergency shelters without severe service needs.
   d) **Fourth Priority.** Homeless persons with a disability coming from transitional housing.
   e) **VA Priority Populations.** Homeless Veterans who do not meet criteria for chronic homelessness or the priority groups

above may be prioritized for VA-funded Permanent Supportive Housing (PSH) if they demonstrate a need for ongoing case management based on clinical assessment. Additional priority populations include, but are not limited, to the following Veterans: women, those with children, those who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), aging Veterans, those with a debilitating clinical condition that does not meet formal disability criteria, and those with an extensive homeless history that does meet other criteria above.

4. If there are no available case management openings or vouchers, the Veteran will be placed on a HUD-VASH Interest List. The Veteran will be provided with information about HUD-VASH, and when appropriate, the HUD-VASH case management team will invite the Veteran to participate in any existing HUD-VASH pre-admission groups, as available. However, Veterans in this category must be referred to other VA and community resources to address their current needs. HUD-VASH staff must document the referral, in CPRS, and note that the reason for denial was a lack of an available voucher or case management openings. Denials for lack of an available voucher should be recorded as such in HUD-VASH Homeless Operations Management and Evaluation System (HOMES) as well.
   a) Veterans who are placed on a HUD-VASH Interest List must be reassessed, by HUD-VASH program Coordinator, or his/her designee, when a voucher becomes available so that the Veteran most in need is admitted to the program.
   b) Veterans on the HUD-VASH Interest List must have a warm handoff to other VA and/or community programs that can assist with ongoing clinical and housing needs

SUPPORTIVE HOUSING PRIORITIZATION

TPCH uses a dynamic prioritization approach in which the most vulnerable households are prioritized for all available housing options regardless of whether the individuals might be better-served in the future by a type of program not presently available to them. This approach is designed to ensure that high-acuity individuals and families are provided with some level of immediate support, rather than left to wait on a list for a higher-intensity intervention that will likely become available for only a very small percentage of individuals in any given year.

TPCH has established two prioritization models as follows:

- Prioritization of individuals and families for projects not designated for youth
- Prioritization of individuals and families for projects designated for youth

Prioritization of Individuals and Families for Projects Not Designated for Youth

Households are prioritized for supportive housing including transitional housing, rapid rehousing, and permanent supportive housing using the following prioritization factors:

- Chronic homeless status/Dedicated Plus eligibility
- Domestic Violence
- Severity of service needs as indicated by VI-SPDAT score of 12 or above
- Risk of severe medical complication associated with COVID-19 as defined by U.S. Centers for Disease Control and Prevention
    - Age 50 or over
    - One or more pregnant person(s) and/or child under the age of 18 in household
    - Currently or previously tested positive for COVID-19
    - Current diagnosis of chronic health condition:
        - Cancer
        - Chronic kidney disease

- Chronic obstructive pulmonary disease (COPD)
- Immunocompromised stated resulting from solid organ transplant
- Obesity (body mass index of 30 or higher)
- Serious heart condition defined as heart failure, coronary artery disease, or cardiomyopathies
- Sickle cell disease
- Type 2 diabetes mellitus

The following represents the uniform process to be used across the community to assess persons, refer them to an intervention, and within each category, prioritize offers of housing.

To house individuals and families, the prioritization will first be filtered into three priority pools.

1. Top Priority: The Top Priority Pool shall consist of households experiencing chronic homelessness and/or fleeing domestic violence, and who meet one or more additional supportive housing prioritization factors as defined above.

   Referrals from the top priority pool will be ordered based on the number of priority factors met such that households with the highest number of priority factors met will be referred first.

   If multiple households meet the same number of priority factors, referrals of those households will be ordered based on the VI-SPDAT score such that households with the highest assessment score are referred first.

   In the event that multiple households within this group have the same VI-SPDAT score, the following factors will be used as tie-breakers. Such households will continue through each tie breaker consecutively until the tie is broken.

   Tie-Breaker 1: Greatest number of days homeless during the current episode of homelessness as recorded in the HMIS (length of time homeless).

   Tie-Breaker 2: Greatest number of days since date of project entry into TPCH Coordinated Entry system for housing assistance (referral date).

2. Second Priority: The second priority pool shall consist of all households not included in the top priority pool which meet one or more supportive housing priority factors as defined above.

   Referrals from the second priority pool will be made only if there are no households awaiting referral from the top priority pool. Referrals from the second priority pool will be made using the same prioritization methodology described for the top priority pool.

3. Third Priority: The third priority pool shall consist of households experiencing homelessness which do not meet any of the supportive housing priority factors as defined above.

   Referrals from the third priority pool will be made only if there are no households awaiting referral from the top or second priority pools. Referrals from the third priority pool will be ordered based on VI-SPDAT score such that the household with the highest score is referred first.

   In the event that multiple households within this group have the same VI-SPDAT score, the following factors will be used as tie-breakers. Such households will continue through each tie breaker consecutively until the tie is broken.

   Tie-Breaker 1: Greatest number of days homeless during the current episode of homelessness as recorded in the HMIS (length of time homeless).

Tie-Breaker 2: Greatest number of days since date of project entry into TPCH Coordinated Entry system for housing assistance (referral date).

Prioritization of Individuals and Families for Projects Designated for Youth

Youth households are prioritized for supportive housing projects designated for youth including transitional housing, rapid rehousing, and permanent supportive housing designated for youth ages 24 and younger using factors that account for the unique circumstances of young adults experiencing homelessness. These prioritization factors are used for two subsets of youth households:

- Unaccompanied youth ages 17+9 months to 24 years
- Parenting youth households in which no member of the household is age 25 or older

Such households are prioritized for supportive housing including transitional housing, rapid rehousing, and permanent supportive housing using the following prioritization factors:

1. History of exploitation/victimization as indicated on the TAY-VI-SPDAT or F-VI-SPDAT.
2. Co-morbidity defined as the presence of two or more of the following as indicated on the TAY-VI-SPDAT or F-VI-SPDAT.
    - Chronic health issue
    - Mental health/substance abuse disorder
    - Disability
3. Risk of severe medical complication associated with COVID-19 as defined by U.S. Centers for Disease Control and Prevention
    - Age 50 or over
    - One or more pregnant person and/or child in household
    - Currently or previously tested positive for COVID-19
    - Current diagnosis of chronic health condition:
        - Cancer
        - Chronic kidney disease
        - Chronic obstructive pulmonary disease (COPD)
        - Immunocompromised stated resulting from solid organ transplant
        - Obesity (body mass index of 30 or higher)
        - Serious heart condition defined as heart failure, coronary artery disease, or cardiomyopathies
        - Sickle cell disease
        - Type 2 diabetes mellitus
4. Recent discharge from jail, child welfare, or juvenile detention, or other institutions within the past 90 days or pending discharge from these institutions within 90 days of assessment
5. Recent discharge from homelessness assistance program for minors or homeless assistance program for family households in which the youth cannot remain within the past 90 days or pending discharge from these programs within 90 days of assessment.
6. Safety and stability of current sleeping location
7. Length of time homeless
8. Disability
9. Severity of service needs (as indicated by TAY-VI-SPDAT or F-VI-SPDAT)
10. Client choice
11. Specialized services offered by supportive housing project (project specialization)

The following represents the uniform process to be used across the community to assess persons, refer them to an intervention, and within each category, prioritize offers of housing.

Priority Pool	Prioritization Process & Associated Factors
Pool 1: Youth Coordinated Entry List	Pool 1 is comprised of all households on the Youth By Name List in which the youth members of the household are between the ages of 17+9 months and 24. Households in Pool 1 are subdivided into two groups by the HMIS Lead: • Households prioritized for supportive housing assistance as defined in Priority Pool 2 below. • Households not prioritized for supportive housing assistance. Such households may be referred to Navigation and/or Diversion services during Youth Case Conferencing based on service capacity and household needs. Households not prioritized for supportive housing assistance may be referred to supportive housing if there are no known households in Pools 2, 3, 4, or 5. Such households shall be prioritized such that households with contact with street outreach, emergency shelter, and/or Coordinated Entry projects in the past 90 days are referred first. Referrals from within this pool will be ordered such that households with the highest TAY-VI-SPDAT or F-VI-SPDAT score are referred. In the event that multiple households within this pool have the same VI-SPDAT score, referrals will be ordered such that households with the greatest number of documented days homeless during the current episode of homelessness are referred first. In the event that there are no households with documented contact in the past 90 days, referrals of households outside of this pool will be prioritized using the same prioritization process as those with contact in the past 90 days.
Pool 2: Supportive Housing Priority Pool	Pool 2 is comprised of all households in Pool 1 which meet Supportive Housing Prioritization Factors 1-5 as defined in the previous section. Households in Pool 2 are subdivided into two groups by the HMIS Lead: • Prioritized households with recent engagement as defined in Priority Pool 3 below. • Prioritized households without recent engagement. Prioritized households without recent engagement will be added to the TPCH Youth Outreach List for continued engagement and/or to document change in housing status, if applicable. Prioritized households without recent engagement may be referred to supportive housing if there are no known households in Pools 3, 4, or 5 and will be prioritized by TAY VI-SPDAT or F VI-SPDAT score. In the event that multiple households have the same VI-SPDAT score, referrals will be ordered such that households with the greatest number of documented days homeless during the current episode of homelessness are referred first.
Pool 3: Prioritized Households with Recent Engagement	Pool 3 is comprised of all households in Pool 2 which have had contact with shelter, supportive service, and/or Coordinated Entry projects documented in the HMIS within the past 30 days.

	Households in Priority Pool 3 will be forwarded to Youth Case Conferencing by the HMIS Lead using the case conferencing worksheet established by the HMIS Lead and Youth Homelessness Demonstration Project Coordinated Entry Action Team. Youth Case Conferencing participants, in collaboration with the HMIS Lead, will subdivide Pool 3 into two groups: • Households known or believed to be document ready as defined in Priority Pool 4 below. • Households known to lack documents or for which document status is unknown. Such households will be referred to Navigation services during Youth Case Conferencing in order to obtain identity documents and will be added to the Supportive Housing Match List (Pool 5).
Pool 4: Prioritized and Document Ready Households	Priority Pool 4 is comprised of all households in Priority Pool 3 which are documented or known to have the following identity documents needed for project eligibility and leasing: • State ID or Driver's License • Income Documents (if applicable) • Social Security card/Immigration documents (if applicable) • Birth certificate • Disability documentation (if applicable) • Evidence of length of time homeless (if household meets chronic homelessness and/or Dedicated Plus eligibility requirements) Households in Priority Pool 4 will be added to the Supportive Housing Match List (Pool 5) for supportive housing referral.
Pool 5: Supportive Housing Match List	Pool 5 is comprised of all households in Priority Pool 3. Referral of households to supportive housing projects from Pool 5 will be directed by Youth Case Conferencing participants using the Supportive Prioritization Factors 6-11 defined above. Priority may be given to households in Pool 4 based on the documentation requirements of the supportive housings project(s) to which referrals are being made.

PERMANENT SUPPORTIVE HOUSING

Community Priorities
Priorities for those who will receive assistance with Permanent Supportive Housing programs.

- Beds dedicated and prioritized to serve families and individuals facing chronic homelessness
- Beds that are not dedicated or prioritized to serve families and individuals facing chronic homelessness

Documentation and Move-In Requirements

- Timelines for obtaining documentation of Chronic Homelessness
- Timelines for accessing housing

Community Priorities

When housing members of the community, this community prioritizes families and individuals with severe service needs who have experienced two or more years of homelessness. This community follows guidelines set forth in (Notice: CPD-16-11). Case

conferencing will be used to further ensure appropriate matching, client choice, and navigation into housing and associated support services offerings.

Due diligence should be exercised when conducting outreach and assessment to ensure that persons are served in the order of priority in these standards, and as adopted by the CoC. HUD recognizes that some persons – particularly those living on the streets or in places not meant for human habitation – might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units vacant where there are persons who meet a higher priority within the CoC and who have not yet accepted the PSH opportunities offered to them. Street outreach providers should continue to make attempts with those persons using a Housing First approach to place as few conditions on a person's housing as possible.

Service needs, defined in detail in the key terms section of this document, are categorized as Severe, High, Moderate, and Low as measured by use of the tools in the SPDAT portfolio.

Beds Classified as Dedicated or Prioritized for Chronically Homeless (CH)

See the key terms section for the definition of Chronic Homelessness.

TPCH seeks to end chronic homelessness. Certain CoC-funded beds have been dedicated or prioritized to serve families and individuals experiencing chronic homelessness. Only persons experiencing chronic homelessness (CH) will be served in CH- dedicated or CH-prioritized beds until all people facing chronic homelessness within our geographic boundaries have been offered housing. Families and individuals with moderate and low service needs are not currently served with these beds.

If an individual or household is referred to a bed designated or prioritized for CH but the individual or households meets the Dedicated Plus definition, that household may be served by the project if it has a vacant bed designated as Dedicated Plus or will be re-referred by the HMIS Lead to the next Dedicated Plus vacancy in the CoC.

Timelines for Obtaining Documentation of Chronic Homelessness

Verification of homeless status and disability are required per HUD. Details on what types of homeless verification are provided in this document under Evaluating and Documenting Eligibility (Categories of Homelessness & Required Types of Verification).

Obtaining verification of disability and chronic homeless status shall not be a barrier to entering housing. When projects are verifying chronic homeless status, TPCH allows projects to require no more than the minimum HUD-required documentation prior to move-in. This includes a review of homelessness with the household to ascertain whether the household qualifies and a primary or secondary source of disability verification. Once the program has enough information from the participant to believe the participant qualifies, s/he should be allowed to move forward with program entry.

The secondary source of disability documentation (social security award letter, handicap parking placard, or written intake worker's notation of a visible disability) allows the program to take up to 45 days to obtain direct third-party disability verification.

Projects are given up to 180 days to obtain written verification of chronic homeless status.

Timelines for Accessing Housing

Programs must make every effort to house participants quickly. Additional barriers may not be imposed, and client-centered assistance must be provided to enable participants a quick turnaround from eligibility determination to move-in.

RAPID REHOUSING PROGRAMS

Introduction

Rapid rehousing assistance helps families and individuals who are experiencing homelessness to move as quickly as possible into permanent housing and achieve stability in that housing through a combination of rental assistance and supportive services. Rapid rehousing rental assistance is available for a maximum of 24 months within a three-year period, which may not be consecutive. Participants may maintain their housing units once the rental assistance has ended by paying full rent to the property. Rapid rehousing uses Fair Market Rates (FMR) established annually by HUD http://www.huduser.org/portal/datasets/fmr.html which includes utility allowances.

Average length of Rapid Rehousing assistance

While each RRH participant is encouraged to reach rent independence as soon as practical, TPCH recognizes that RRH participants may require time for completing education and/or job training, job search, and other endeavors that contribute to housing stability. Clients are generally expected to assume 100% of their rent after 8 months of assistance with the exception of youth ages 18-24 which are generally expected to assume 100% of their rent after 12 months of assistance.

Priorities for which families and individuals will receive Rapid Rehousing assistance

Rapid Rehousing programs will use SPDAT tools (through the HMIS per Coordinated Entry) to determine and prioritize who will receive RRH assistance. Households with moderate or severe service needs will be offered rapid rehousing assistance. Families and individuals with low service needs are not currently served with these beds.

Participants must meet the HUD definition of homelessness for Categories 1, 2, or 4. Households must lack sufficient resources and support networks to sustain stability in permanent housing. Rapid Rehousing will be offered on a Housing First basis and re-house households in less than 30 days. Rapid Rehousing utilizes the Transition-In-Place model which allows program participants to retain the unit when the rental assistance and supportive services end.

Standards for determining what percentage or amount of rent each program participant must pay while receiving Rapid Rehousing assistance

The percentage of income each household will pay will increase over time. (NOTE: participants without income will not pay rent; x% of 0 = 0). The rent the participant pays shall not exceed the rental costs on the unit; programs will not profit from participant contributions. Annual earnings are divided by 12 months to calculate a monthly earning amount.

The rent schedule is as follows:

Participants in short-term rental assistance (1-3 months in duration) may pay up to 10% of their income for rent and utilities.
Participants in medium-term rental assistance (4-8 months) may pay up to 25% of their income for rent and utilities.
Participants in long term rental assistance (months 9-24) may pay up to 50% of their income for rent and utilities.

At no point shall the rent collected from the household exceed the lease rent on the property.

Standards regarding utility assistance

If utilities are not included in a project participant's rent, the agency administering the project grant will pay the utilities up to the amount of the participant's utility allowance, which shall not exceed FMR. If the cost of such utilities exceeds the amount of the utility allowance, the project or project participant must pay the excess amount from other sources.

Standards for case management with Rapid Rehousing Assistance.

All agencies are expected to assist their RRH project participants in accessing or increasing income and to obtain or maintain mainstream benefits (e.g. health insurance, nutritional assistance, child care) to which they may be entitled. All agencies also are expected to progressively engage their clients in case management and all other services (e.g. education, job training, job development, budgeting) that they may need to attain and maintain housing stability. Agencies may neither require participation in services either to obtain or maintain housing nor may they exit a project participant from housing for non-participation in services.

Projects are expected to identify clients among their participants who may be Chronically Homeless and to verify length of time

homeless and disabling conditions to facilitate potential transfers.

TRANSITIONAL HOUSING

Introduction

Transitional Housing (TH) facilitates the movement of homeless families and individuals to permanent housing within 24 months of entering Transitional Housing.

Community Priorities

Transitional Housing programs will use SPDAT tools (through the HMIS per Coordinated Entry) to determine and prioritize who will receive assistance. Households with moderate service needs will be offered assistance; priority going to households who are less likely to be able to secure a lease in their own name. . Families and individuals with low service needs are not served with these CoC-funded beds.

Eligibility

Participants must meet the HUD definition of homelessness Categories 1, 2 or 4.

Documentation Protocol

Documentation to verify homeless status must be obtained per the Evaluating and Documenting Eligibility (Categories of Homelessness & Required Types of Verification) section of this document.

Projects are expected to identify clients among their participants who may be Chronically Homeless and to verify length of time homeless and disabling conditions to facilitate potential transfers.

EVALUATING & DOCUMENTING ELIGIBILITY

HUD further defines homelessness into various categories. This section contains the category definitions and documentation requirements for each level of homelessness. Procedures for evaluating and documenting eligibility are unique to each category of homelessness. HUD has two levels of documentation; Level 2 is only acceptable if level 1 documentation cannot be obtained.

Literally Homeless (also referred to as Category 1)

An individual or family sleeping in an emergency shelter or a Safe Haven (Sonora House), sleeping in a place not meant for human habitation, (staying in someone else's residence does **not** meet the requirements for literal homeless), or exiting an institution where s/he has resided for 90 days or less and was at one of the above places immediately before entering the institution.

Level 1 Options:

- Written observation by the outreach worker
- Written referral by another housing or service provider

Level 2 Options (to be obtained when none of the above are available)

- Certification by the individual or head of household seeking assistance stating that s(he) was living on the streets or in shelter PLUS documentation outlining efforts to obtain both level 1 forms of documentation.

For individuals exiting an institution obtain one of the forms of evidence above for where the person slept prior to entering the institution and one of the following regarding the institution stay:

- Discharge paperwork or written/oral referral

- Written record of intake worker's due diligence to obtain the evidence and certification by individual that they exited institution

At Imminent Risk of Homelessness (also referred to as Category 2)

An individual or family who will imminently lose their primary nighttime residence is considered to be imminently homeless if the residence will be lost within 14 days of the application for homeless assistance, no subsequent residence has been identified and the individual or family lacks the resources or support networks needed to obtain other permanent housing.

Level 1 Options:

- If in housing, a court order resulting from an eviction action notifying the individual or family that they must leave. If in a motel; evidence showing they lack the financial resources to stay.

Level 2 Options consist of three components, all of which must be obtained:

- A documented and verified oral statement with certification that no subsequent residence has been identified
- Self-certification or other written documentation that the individual lacks the financial resources and support necessary to obtain permanent housing.
- Documentation outlining efforts to obtain the level 1 documentation.

Homeless under other Federal Statutes (Category 3) This category is available for RHY and ESG programs; Category 3 households are not eligible for COC programs

Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

i) Are defined as homeless under the other listed federal statues;
ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
iii) Have experienced persistent instability as measured by two moves or more during the preceding 60 days; and
iv) Can be expected to continue in such status for an extended period due to special needs or barriers.

There are no level 2 sources of documentation for this category, all of the following must be obtained:

v) Certification by the nonprofit, state or local government that the individual or head of household seeking assistance met the criteria of homelessness under another federal statute
vi) Certification of no permanent housing in the last 60 days
vii) Certification by the individual or head of household, and any available supporting documentation, that (s)he has moved two or more times in the past 60 days
viii) Documentation of special needs or two (2) or more barriers

Fleeing/Attempting to flee domestic violence (Category 4)

An individual or family is considered to be fleeing domestic violence when fleeing, or attempting to flee, domestic violence, has no other residence and lacks the resources or support networks to obtain other permanent housing. There are no level 2 sources of documentation for this category.

For victim service providers:

- An oral statement by the individual or head of household seeking assistance which states: they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker.

For non-victim service providers all of the below must be gathered:

- Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker.
- Certification that no subsequent residence has been identified
- Self-certification or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

Chronic Homelessness

See the key terms section for the definition of Chronic Homelessness.

Projects must document households meeting the HUD criteria for chronic homelessness. This documentation includes three things

i) Documentation of the current household status as Category 1; Literally Homeless.
ii) Documentation of disability
iii) Documentation of the homeless history required to qualify as chronically homeless.

These documents may be obtained after the household has moved in. These documents have levels of documentation as prescribed by HUD. Time spent homeless must be verified; breaks in homelessness do not require third-party verification.

Level 1: Third-Party documentation. This includes written observation by an outreach worker, a written referral by another housing or service provider, or documentation from institutions such as hospitals, correctional facilities, etc. when they include length of stay and are signed by the institution staff. HMIS data may be used in when it contains the information required of all third-party documentation.

Level 2: Self-Certification. This is a signed certification by the individual seeking assistance describing how they meet the definition accompanied with the intake worker's documentation of the living situation and the steps taken to obtain evidence to support this. (A minimum of 5 must be made, and documented, to entities that could provide third-party verification).

Projects are capped at the number of households that can self-certify. A household's documentation packet is considered complete when it verifies disability and third-party verification for at least 9 months of the household's time homeless. 75% of the project's households must have complete documentation packets on file. 25% of the project's households may self-certify all of their time homeless.

REFERENCES

24 CFR 578 HEARTH Act (amending McKinney-Vento Act) and all subsequent amendments

U.S. Department of Housing and Urban Development Notice CPD 16-11: Prioritizing Persons Experiencing Chronic Homeless and Other Vulnerable Homeless Persons in Permanent Supportive Housing.

U.S. Department of Housing and Urban Development Notice CPD 17-01: Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System

END OF EXHIBIT B-1

TUCSON PIMA COLLABORATION TO END HOMELESSNESS
CONTINUUM OF CARE PROGRAM PERFORMANCE STANDARDS (2021)

HOUSING PROJECT MEASURES	TH/RRH	PSH	SH Residential	SH Total Project	Navigation
Fund Utilization: Percentage of Grant award expended at end of project period.	90%	90%	90%	90%	90%
Coordinated Entry: Percentage of all households served referred through the Coordinated Entry system	100%	100%	100%	No standard	No standard
Inventory Utilization: Percentage of units (projects in which 1 household occupies each unit) or beds (projects in which multiple households share a housing unit) for which grant funds were awarded that are occupied on the night of quarterly point in time counts	95%	95%	93%	90%	90%
Income Change at Exit: Percentage of leavers with increased income at exit	50%	50%	50%	20%	No standard
Income Change at Annual Assessment: Percentage of stayers with increased income at annual assessment	40%	40%	40%	20%	No standard
Households Receiving Outside Assistance*	No standard	No standard	No standard	No standard	80%
Exits to Permanent Housing: Percentage of leavers who exited to permanent housing destinations	80%	80%	80%	35%	No standard
Exit/Retention of Permanent Housing: Percentage of households served which exited to permanent housing destinations or retained permanent housing	No standard	90%	No standard	No standard	65%
Returns to Homelessness: Percentage of leavers to permanent housing destinations which returned to homelessness within 12 months *(measurement processing to be determined in CY21)*	15%	15%	15%	No standard	No standard
Prompt Access to Housing: Average length of time (in days) between project/referral acceptance and housing move-in	30 days	30 days	30 days	No standard	60 days
Cost Per Successful Exit: Average CoC Program grant cost per household exiting to permanent housing	No standard (measured/reported for information gathering)				
HMIS Data Quality: Number of Project Entry/Exit Records Exceeding 3 Days	0	0	0	0	0
HMIS Data Completeness (Percentage)	90%	90%	90%	90%	90%

*Outside assistance defined as cash benefits, non-cash benefits, health insurance, workforce development services, education/training, legal services, or child care.

April 2021

END OF EXHIBIT C-1