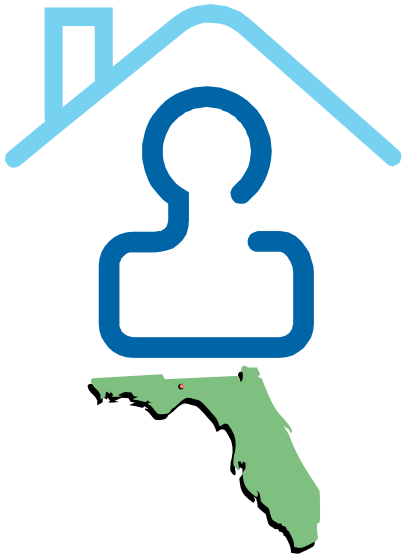
# Northeast Florida Continuum of Care
# Written Standards of Operating Policies & Procedures
# For
# Coordinated Intake & Assessment



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- The many homeless housing stakeholders of Northeast Florida
- The ongoing work of the Coordinated Intake and Assessment Committee ; and,
- The Emergency Services and Homeless Coalition of Northeast Florida

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## INTRODUCTION

National research has highlighted Coordinated Intake & Assessment as a key factor in the success of ending homelessness. Coordinated Intake & Assessment can enhance the quality of client screening and assessment and better target program assistance where it can be most effective. As a result, the system for preventing and ending homelessness is less fragmented and scarce resources are used more efficiently.

### What is Coordinated Intake & Assessment?

Coordinated Intake & Assessment for Northeast Florida CoC is a hybrid of a decentralized (access points in the three county area), outreach, web-based and telephone based centralized intake model. Initial screening can be conducted for all populations either at one of the intake hot spots, through a Navigator, over the phone or through a web-based component. Coordinated Intake & Assessment includes the following core components:

- Information so that people will know where or how to access intake for homeless prevention or housing services;
- A screening and assessment process and tools to gather and verify information about the person and his/her housing and service needs and program eligibility and priority;
- Information about programs and agencies that can provide needed housing or services;
- A process and tools for referral of the person to an appropriate programs or agencies; and assistance in making program admissions decisions

While most housing and services are made available through other agencies, a variety of services may be provided on site at the "Access Points" or by a "Navigator". These services typically meet basic client needs and may include diversion services, crisis counseling, landlord/tenant mediation, motel vouchers, JTA bus pass or transportation to an agency and/or access to mainstream resources.

## KEY TERMS

A number of key terms are subject to varying interpretations and thus should be defined for purposes of this document. They are as follows:

- **Access Points –** For the purpose of this document, Access Points are designated areas located within our continuum where individuals or families can go to for intake and assessment of homeless prevention and housing services for which they may qualify.
- **Admission –** Using authority to admit a client into a program
- **Assessment –** A process that reveals the past and current details of a service seeker's strength, and needs, in order to match the client to appropriate services and housing. For the purpose of this toolkit, assessment will refer to a process (whether at primary screening and intake or at entry to a housing program) that reveals a client's eligibility, needs, barriers and strengths.
- **Chronic Homelessness- A chronically homeless individual is someone who has** experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years and has a disability. A family with an adult member who meets this description would also be considered chronically homeless.
- **Coordinated Assessment –** For this area, this term specifically relates to the providers within our continuum that uses the same assessment tools to connect clients to services as a means for a coordinated entry system. For the purpose of this document, that tool is the SPDAT (The Service Prioritization Decision Assistance Tool)
- **Coordinated Intake Board-** Entity responsible for implementation and upper level management of Coordinated Intake System. Members of the Board are selected by ESHC and submitted to a process of approval by existing board members.
- **Coordinated Systems –** Within our community, coordinated systems is defined as interconnected network of systems that services homeless and at risk households, and consists of coordinated intake and assessment, diversion, prevention, rapid re-housing, transitional housing, permanent supportive housing and other tailored programs and services, and linkages to mainstream resources.
- **Fiscal Agent –** For the purpose of this document, the entity that coordinates funding and provides oversight to the coordinated intake and assessment system. The fiscal agent for this community will be the Emergency Services & Homeless Coalition of Northeast Florida This agent is also known as the "Lead Agency"
- **HEARTH –** The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that includes Emergency Solutions Grant (ESG) and Continuum of Care (CoC) grants.
- **HMIS –** Homeless Management Information System; a centralized data base designated to create an unduplicated accounting of homelessness that includes housing and services. Client Track is the HMIS system for this CoC.

- **Homeless –** HUD definition as of January 2012; an individual or family who lacks a fixed regular, and adequate nighttime residence, which includes a primary nighttime residence of: a place not designed for or ordinarily used as a regular sleeping accommodation (including car, park, abandoned building, bus/train station, airport or camping grounds); a publicly or privately operated shelter or transitional housing, including a hotel or motel paid for by government or charitable organizations. In addition a person is considered homeless if he or she is being discharged from an institution where he or she has been a resident for 90 days or less and the person resided in shelter (but not transitional housing) or place not meant for human habitation immediately prior to entering the institution.
- **Housing First –** An Evidence-Based Practice of housing homeless individuals and families according to the provisions of a standard lease without requiring services other than case management in order to attain and retain housing.
- **Housing Ready –** A case management/housing approach that placed homeless households into permanent housing only when determined the household was ready. Until that time, households were placed into long-term shelter or transitional housing programs. The approach is being replaced by the Evidence Based Practice of Housing Frist and an approach known as "rapid re-housing."
- **HUD –** The Department of Housing and Urban Development; the United States federal department that administers federal program dealing with homelessness. HUD oversees HEARTH-funded programs.
- **Information –** Specific facts about a program, such as its location, services provided, eligibility requirements, hours of operation, and contact information
- **Intake** – the general process between the client first point of contact and the initial screening for eligibility. This step involves primary assessment of needs, strengths and resources to refer households into appropriate services
- **Lead Agency –** The agency identified as the primary administrator of coordinated intake and assessment. For the purpose of this document that agency is the Emergency Services & Homeless Coalition of Northeast Florida or its sub-grantee who has been contracted to provide the Coordinated Intake and Assessment Services.
- **Linkage or Access to Mainstream Resources –** An approach to help people stabilize their housing for the long term by linking them to resources for which they are eligible within their community.

- **Navigator –** A certified intake worker whose responsibility is to provide coordinated intake and assessment for individuals or families seeking homeless prevention or housing services.

- **Outcome –** The specific result of what was provided from a specific activity or service; in relation to HUD/HEARTH, a specific result as detailed by HUD/HEARTH funding requirements.
- **Prevention –** An approach that focuses on preventing homelessness by providing assistance to households that otherwise would become homeless and end up in a shelter or on the streets.
- **Rapid Re-housing –** An approach that focuses on moving homeless individuals and families into appropriate housing as quickly as possible by providing the type, amount and duration of housing assistance needed to stabilize the household. Clients do not need to be considered "Housing Ready".
- **Referral –** Referring a client to a particular program for possible help
- **Screening –** For the purpose of this document, the process by which eligibility for housing and services is determined at the initial point of contact to a coordinated entry system. Once screening determines eligibility, the intake and referral process follows.
- **Systems Change –** For the purpose of this document, the process by which our CoC has altered the way homeless and at-risk households engage with the homeless and housing providers within our communities. The purpose of system change is to implement practices that have shown to decrease the incidence and length of time in homelessness, with a long term goal of reducing and ending homelessness.
- **Tailored Programs and Services –** An approach to case management services that matches the services to the particular individual's or family's needs rather than using a one-size-fits-all approach.
- **Targeting –** Process of determining the population to whom assistance will be directed. That is, the target population. The targeting process can occur at both the system and the program levels.
- **Coordinated Intake Provider Network –** is a consortium of partners that includes homeless service providers, advocacy groups, government agencies, and homeless individuals who are working together to address the housing and support needs of the homeless in Northeast Florida
- **Verification –** The gathering and review of information to substantiate the applicant's/client's situation and support program eligibility and priority determination.

## ENTRY SYSTEM

Duval, Nassau and Clay counties are located in Northeast Florida and span over 2,286 square miles of diverse geographic and demographic landscape. Duval County is a populated metropolitan area, Nassau County consists of both rural and beaches community and Clay County is mostly rural with pockets of suburban neighborhoods. In order to meet the need of our community we will utilize a hybrid approach incorporating Access Points, Navigator, and web based components to provide a variety of avenues in which all segment of our community can access housing and service supports.

**Applicants and Clients :**

- Clients who are in need of homeless prevention or housing services can access information and eligibility criteria through one of the Access Points. Applicants seeking assistance must be screened at one of the Access Points or by a Navigator prior to being referred to an agency for assistance. Applicants not eligible for services will be referred to other appropriate community resources.
- Eligibility. Individuals and families that are **"Literally Homeless"** (meeting HUD's Category 1 definition of homelessness) or at **"Imminent Risk of Homelessness"**. For purposes of eligibility for coordinated intake and assessment, "imminent risk of homelessness" means individuals and families that are able to document that they must leave their current nighttime residence within 72 hours, and include household that;
    - Have received a court notice of eviction or foreclosure.
    - Are staying with family or friends AND can document that they must leave within 72 hours. Documentation must include a third party verification of violation. (For example, a lease that states that anyone other than occupants in the lease constitutes a lease violation.)
    - Other, as determine by a provider or by the Northeast Florida CoC
- Participation Requirement. All households (with the exception of households in domestic violence situations) must be assessed prior to program entry; or , in the case of households in emergency shelters that admit same day, the assessment must occur as soon as possible after entry, and before being referred to another program

- Applicants/Clients can expect :
    - To be treated with respect and dignity
    - Their initial phone call for assistance to be answered live or returned within two business days
    - To be scheduled for an in-person, intake and assessment within two to five business days
    - To be matched to an appropriate program based upon their unique needs, and referred based on their priority status to opening in a program

- To wait until the system has the capacity to assist them, and to get help from through diversion or other resource available to them.

- Responsibilities. Client must:
  - Answer all questions truthfully and to the best of their ability
  - Bring all required documentation
  - Keep their contact information current in order to be notified of available opening, and referred in a timely manner.

**Providers :**

- Participation Requirement.
  - All providers receiving funding through HEARTH or a HUD funded program are required to participate in the coordinated intake and assessment process.
  - Providers must be live on the HMIS system and must maintain data which is inputted no later than within 24 hours of a service or outcome being achieved or rendered.
  - Providers must provide written documentation to the Coordinated Intake Board within 3 business days on why an applicant was denied entry into a program.
  - Providers must have an appeal process for those applicants who have been denied service or entry into a program.

**Lead Agency :**

- It is the lead agency responsibilities to:
  - Update and maintain information on program vacancies/opening. This must be done on a daily or weekly basis regardless of whether there are new openings to report.
  - Regularly update and make current all programs eligibility guidelines and program contact information so that Navigators can make the best referrals possible.
  - Ensure that when a referral is made, the Navigators confirms within two business days whether the referral is accepted, declined by provider, declined by client, or pending, or the provider is unable to contact the client.
  - Bring problems and suggestions to the monthly Data Committee meeting and/or Coordinated Intake and Assessment meeting.
  - Oversee provision of homeless diversion, prevention and housing services for eligible clients.
  - Ensure that all points of entry will use the same screening and assessment tool, data collection forms, policies on eligibility verification and referral/information-sharing systems.

**NOTE :** *This system acknowledges that the needs of a household fleeing or attempting to flee, domestic violence , dating violence, sexual assault or stalking, may be different than the needs of non-victims. Navigators will be trained on sensitivity in regards to victim's assistance, and referrals will only be made to domestic violence providers. In addition, the HMIS data of victims will continue to be treated with the highest level of confidentiality and victims' data not shared with other Providers (except those designated as Domestic Violence Providers).*

## ASSESSMENT TOOLS & PROTOCOLS

This system is focused on providing a continuum of care including prevention, diversion and rapid re-housing approaches. The Plan requires each Navigator to assess household's eligibility for services. Prevention services target people at imminent risk of homelessness, while diversion services target people as they are applying for entry into shelter, and rapid re-housing services target people who are already homeless. If they client is considered chronically homeless the assessment will be made to a permanent supportive housing program or permanent housing program such as the Jacksonville Housing Authority.

**Applicants and Clients :**

- Each applicant is evaluated on a variety of criterion, including rental history, criminal history, domestic violence, mental health challenges, disabling conditions, language barriers, educational attainment, employment status, and length of homelessness. Services are then assigned based on the client level determination.
- The Assessment tool provides a procedure for determining which applicants are eligible and appropriate for the variety of housing and support services available in the community. For example, applicants for permanent supportive housing must have a disabling condition and lack the resources to obtain housing.
- Clients will be allowed to submit a survey for improvement changes and suggestions on the Coordinated Intake and Assessment process.

**Providers :**

- Each applicant who is referred for housing or services will be evaluated through an assessment of their current barriers to obtaining and successfully maintain permanent housing.
- The assessment is heavily focused on the applicant's immediate housing challenge and includes questions regarding household composition, current housing situation, homelessness history, evictions, criminal history and/or active warrants, physical and mental health, and domestic violence issues.
- The Assessment will be used as a guide, with the understanding that each applicant has a unique set of circumstances.

- Generally speaking, the assessment tool ensures that protocols are applied consistently throughout the three county region (Duval, Nassau and Clay County), and that each Provider is engaging in responsible assessments protocol.

**Lead Agency :**

- The Service Prioritization Decision Assistance Tool (SPDAT) is the assessment tool utilized for this system.
- The SPDAT will utilize 15 dimensions to determine an acuity score that will help inform Navigators and Providers about the following :
  - ✓ People who will benefit most from Permanent Supportive Housing
  - ✓ People who will benefit most from Rapid Re-Housing
  - ✓ People who are most likely to end their own homelessness with little to no intervention on your part
  - ✓ Which areas of the person's life that can be the initial focus of attention in the case management relationship to improve housing stability.
  - ✓ How individuals and families are changing over time as result of case management process.
- The SPDAT will be integrated into the HMIS System and the lead agency will ensure data is being maintained and monitored.
- The Lead Agency will provide a system of care that allows clients to give feedback on suggestions and improvements of the Intake and Assessment Process. This process will be posted in common areas of "Access Points" and made available on-line as part of the Web-based system.
- The Lead Agency will ensure that the SPDAT is not used to :
  - Provide a diagnosis
  - Assess current risk or be a predictive index for future risk
  - Take the place of other valid and reliable instruments used in clinical research and care

## PRIORITIZATION PROCEDURES & PROTOCOL

One of the main purposes of Coordinated Intake and Assessment is to ensure that people with the most severe service needs and levels of vulnerability are prioritized for housing and homeless assistance. As indicated by HUD guidelines individuals and families experiencing chronic homelessness should be prioritized for permanent supportive housing.

In addition to prioritizing chronic homelessness, Coordinated Intake and Assessment will prioritize people who are more likely to need some sort form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness.

HUD has released the following criteria to consider how to prioritize individuals and families for housing and homeless assistance:

- Significant health or behavioral challenges or functional impairments which require a significant level of support in order to maintain permanent housing
- High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities to meet basic needs
- The extent which households, especially youth and children, are unsheltered
- Vulnerability to illness or death
- Risk of continued homelessness
- Vulnerability to victimization, including physical assault or engaging in trafficking or sex work

The Northeast Florida Coordinated Entry System will utilize the VISPDAT assessment scores to identify interventions that may be best appropriate for families seeking assistance. Assessment scores will be characterized by the following breakouts:

- Scores 10 and above will be prioritized for PSH interventions
- Scores 5-9 will be prioritized for RRH and/or TH interventions
- Scores 4 and below will be prioritized for Prevention/Diversion and other community resources

<u>Prioritization for Permanent Supportive Housing:</u>

In order for a household to qualify for PSH interventions they must meet the definition of chronically homeless as defined by HUD. The definition of "chronically homeless" currently in effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:

(a) An individual who

a. Is homeless and lives in a place not meant for habitation, a safe haven, or in an emergency shelter
b. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last three years
c. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury or chronic physical illness

(b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility for fewer than 90 days and met all the criteria outlined in section (a)

(c) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all the criteria in section (a), including a family whose composition has fluctuated while the head of household has been homeless.

In accordance with HUD Notice CPD-014-12, households scoring in the permanent supportive housing range will be prioritized in the following manner:

- **First Priority- Chronically Homeless Individuals and Families with the longest history of homelessness and with the most severe service needs**
  - Household's length of time homeless will be determined by length of time as reported by homeless household during the VISPDAT assessment in combination with a review of their HMIS record. Households must be able to demonstrate history of homeless by producing required documentation.
  - Service needs will be identified by the acuity captured in the VISDPAT assessment. When applicable, portions of the SPDAT targeting the use of crisis services will be administered to the head of household if the household's needs are not accurately captured by the VISPDAT.

- **Second Priority- Chronically Homeless Individuals and Families with the longest history of homelessness**
  - The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at **least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months** and the **CoC or CoC program recipient has NOT identified** an individual or a head of household, who meets

all the criteria of the definition for chronically homeless, of the family as having severe service needs

- Household's length of time homeless will be determined by length of time as reported by homeless household during the VISPDAT assessment in combination with a review of their HMIS record. Households must be able to demonstrate history of homeless by producing required documentation

- **Third Priority- Chronically Homeless Individuals and Families with the most severe needs**
  - The chronically homeless individual or head of household of a family has been homeless and living or residing in a place not meant for habitation, a safe have or an emergency shelter **on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year**, and the **CoC or CoC recipient has identified ta chronically homeless individual or head of household**, who meets all of the criteria of the definition for chronically homeless, of the family **as having severe service needs**.
  - Service needs will be identified by the acuity captured in the VISDPAT assessment. When applicable, portions of the SPDAT targeting the use of crisis services will be administered to the head of household if the household's needs are not accurately captured by the VISPDAT.

- **Forth Priority- All other chronically Homeless Individuals and Families**
  - The chronically homeless individual or head of house household has been homeless and living in a place not meant for human habitation, a safe haven or in an emergency shelter for at **least 12 months either continuously or on at least four separate occasions in the last 3 years where the cumulative total length of the four occasions is less than 12 months** and the CoC or CoC program recipient has **NOT identified a chronically homeless individual or head of household** who meets all the criteria of the definition for chronically homeless as having severe service needs

## PREVENTION / DIVERSION

According to the National Alliance to End Homelessness many people seeking homeless assistance still have an opportunity to remain in their current housing situation, whether it's their own housing or the housing of a friend, relative, acquaintance or coworker. In light of this prevention and shelter diversion are key interventions in the fight to end homelessness. Immediate screening for these possibilities at entry is an important tactic, and can preserve emergency beds for households that truly have nowhere else to go. Access to rental subsidies and case management at entry is often enough to ensure the household successfully remain housed.

While prevention and diversion are two separate concepts, they are utilized almost interchangeably in this strategy, as they both focus on preventing homelessness. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.

Once household enter into the system, they should be assessed to determine what housing needs they have. To determine which households are appropriate for prevention/diversion, Navigators can ask applicants a series of questions during the assessment, such as those delineated below.

**Client :**

Clients who are being referred for prevention/diversion will:

- Be asked where did you sleep last night? *If they slept somewhere safe where they could potentially stay again, this might mean they are good candidates for diversion*
- Be asked what other options do you have for the next few days or week? *Even if there is an option outside of shelter that is only available for a very short time, it worth exploring if this housing resource can be used.*
- (If staying in someone else's housing) What issues exist with you remaining in your current housing situation? Can those issues be resolved with financial assistance, case management, etc? *If the issues can be solved with case management, mediation, or financial assistance (or all of the above), diversion is a good option.*
- (If coming from their own unit) Is it possible/safe to stay in your current housing unit? What resources would you need to do that (financial assistance, case management, mediation, transportation, etc.)? *If the individual or family could stay in their current housing with some assistance, systems should focus on a quick prevention-oriented solution that will keep the individual or family in their unit.*

**Providers :**

Candidates for referrals to prevention/diversion providers will be at imminent risk of homelessness AND meet the following threshold.

- No appropriate subsequent housing options have been identified;
- The household lacks the financial resources to obtain immediate housing or remain in its existing housing; and
- The household lacks support networks needed to obtain immediate housing or remain in its existing housing

**Lead Agency :**

The following list includes some, but not all risk factors that may be considered when determining imminent risk of homelessness:

- Eviction within two weeks from a private dwelling (including housing provided by family or friends)
- Discharge within two weeks from an institution (including prisons, mental health institutions, hospitals);
- Residency in housing that has been condemned by housing officials and is no longer meant for human habitation;
- Sudden and significant loss of income
- Sudden and significant increase in utility cost
- Mental health and/or substance abuse issues
- Physical disabilities and other chronic health issues including HIV/AIDS
- Severe housing cost burden (greater than 50% of income for housing costs);
- Homeless in last 12 months
- Young head of household (under 25 with children or pregnant)
- Current or past involvement with child welfare, including foster care
- Pending foreclosure of rental housing
- Extremely low income ( less than 30% of AMI );
- High overcrowding (the number of person exceeds health and/or safety standards for housing unit size)
- Past institutional care (prison, treatment facility, hospital)
- Recent traumatic life event, such as death of a spouse or primary care provider, or recent health crisis that prevented the household from meeting its financial responsibilities.
- Credit problems that preclude obtaining of housing or
- Significant amount of medical debt.

Some applicants may not be good candidates for diversion programs due to a lack of safe and appropriate housing alternative and require immediate admittance to shelter, e.g. client fleeing domestic violence. A client's safety should always be the top consideration when developing an individual /household referral to a program

## RAPID REHOUSING

Generally, rapid re-housing is intended to assist eligible participants to quickly obtain and sustain stable, permanent housing. Effective rapid re-housing requires case management and financial assistance, as well as housing search and locations services. Support and duration of service are tailored to meet the needs of each household and each household has a lease in their name and is connected to mainstream resources in the community in which they reside.

**Clients :**

Eligible households must:

- Be literally homeless as defined by HUD
- Be prepared to put together a reasonable plan that shows how they are going to maintain housing once housing assistance has ended, a budget, a financial worksheet and or a narrative description of changes in household circumstances that made them homeless.

**Providers :**

Providers who are rapid re-housing grantees:

- Will utilize the **"Progressive Engagement"** methodology; that is, providers will determine the amount of rent and utility assistance and/or supportive services that a household will receive using the progressive engagement approach. Household will be asked to identify the minimum amount and duration of assistance needed to achieve housing stability. If it becomes clear after 90 days that the amount and duration of assistance are not enough, the household will be reassessed, and the amount and duration of assistance may be adjusted. If it becomes clear that a rapid re-housing intervention is insufficient and or inappropriate for a particular household, the provider will work with the Intake Navigator and/or other housing provider to find a more suitable program.
- Households should be housed within 30 days of acceptance into the program.
- Providers are responsible for confirming the household homeless status
- Providers are expected to remain engaged with the household from first contact to program exit.

**Lead Agency :**

The following process will be used to refer clients to any Rapid Re-Housing program. Providers will receive referrals from any of the following sources, provided they have been assessed by the coordinated intake worker and all eligibility and vacancy information is up to date in HMIS.

- Coordinated Access Points and/or Outreach Workers
- Shelters
- Transitional Housing Programs

All household being referred for Rapid Re-Housing must be assessed by a Intake Navigator. While they may be identified through other resources, e,g., shelter or transitional housing provides, McKinney-Vento Liaisons in school districts, or other services providers, they will

require screening and assessment through the Northeast Florida Coordinated Intake and Assessment System.

- Navigators are responsible for gathering documentation for verification of homeless status.
- All Rapid Re-Housing clients must be entered into HMIS by the Navigator once the provider has confirmed entry into the program. Information should all include all HUD required data elements.

## HOUSING AND/OR MORE INTENTSIVE PROGRAM REFERRAL

Consumers unable to be served by prevention, diversion or rapid re-housing programs will most likely need more intensive housing and service interventions, such as transitional housing or permanent supportive housing. Those fleeing domestic violence that are not eligible or appropriate for prevention and rapid re-housing services may fall into this category of needing more intensive service intervention, and should be referred to a domestic violence provider prior to intake and/or HMIS data entry.

Table 1 below delineates the characteristics of Permanent Support Housing and Transitional Housing Programs.

Characteristics of Transitional Housing & Permanent Supportive Housing Programs

| **Programs & Characteristics** | **Transitional Housing** | **Permanent Supportive Housing** |
|---|---|---|
| **Length of Stay** | Maximum stay 24 month | No time limit |
| **Occupancy Agreement** | Participant are clients , not tenants and sign an occupancy or program agreement instead of a lease | Participant have a lease |
| **Service Requirements** | Service are required | Services are optional |
| **Eligibility** | Applicant must meet HUD's definition of homeless | Applicant must meet HUD's definition of homeless and member of the household must have a disabling condition |

**Provider:**

Transitional Housing: programs whom provide transitional housing should provide housing to individuals and/or families, usually for period of six to twenty-four months along with supportive services to help them become self-sufficient. In addition to providing a place to live, transitional housing providers should help participant to increase their life management skills and resolve the problems that have contributed to their homelessness. Household who are homeless and have two or more of the following barriers are appropriate for referral to Transitional Housing:

- Domestic Violence victims (require only one barrier: being a victim of domestic violence.)
- No income
- Poor rental history
- Sporadic employment history
- No high school diploma or GED
- History of homelessness
- Poor rental history (i.e current eviction, rent/utility arrears )

Transitional housing best serves individuals and families with the potential to be self-sufficient, who may just need longer term case management to be successful.

Permanent Supportive Housing: As a minimum, candidates for Permanent Supportive Housing must meet the following basic requirements:

- Is literally homeless
- Lacks the resources to obtain housing
- Has a member of the household with a severe or significant disabling condition
- Qualifies as a high need based on the Intake and Assessment

Permanent Supportive Housing is targeted to household who need services in order to maintain housing and there is prioritization for people who have been homeless for long periods of time or have experienced repeat episodes of homelessness.

**Lead Agency :**

The outreach navigator provides needed housing navigation services, is in frequent communication with the client and serves as the primary liaison between the client and the housing provider. The Lead Agency is responsible for overseeing and ensuring that:

- Advocacy and services to collect required housing documentation are provided
- In-reach and outreach are available and provided depending on service provider's system already in place, to accomplish the task of completing the housing document checklist.
- A climate of trust is created and maintained between clients and navigators.
- A housing inventory within HMIS is maintained that lists units and vouchers participating within the system.
- Clients are housed based upon a prioritization determination; that is, those who score on the SPADAT as the most vulnerable should be prioritized for housing.

## UNACCOMPANIED YOUTH AND YOUNG ADULTS

The Department of Health and Human Services Administration for Children, Youth and Families emphasizes that youth who run away from home are often mistakenly portrayed as juvenile delinquents. In contrast, such behaviors often reflect society's failure to develop adequate support which includes homeless services. Unaccompanied youths are one of the fastest growing and most underserved sub- populations, in our community. In addition, it is important to note that Lesbian, Gay, Bisexual, Transgendered, Questioning, and Intersexed, as well as African American youth and young adults are disproportionately impacted when compared to other groups.

**Clients :**

Unaccompanied Youth and Young Adults are defined as youth (ages 13-17) and young adults (ages 18-24) who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed , regular and adequate nighttime residence. Undocumented unaccompanied youth and young adults may also be served under these provisions except where exclusions are noted

**Providers :**

Providers of services for unaccompanied youth and young adults should be able to provide safe and high quality housing and supportive services (scattered-site independent apartments, host homes, and shared housing) to youth and young adults experiencing homelessness that involve an integrated constellation of affordable housing, intensive strengths-based case management, self-sufficiency services, trauma informed care, and positive youth development approaches.

**Lead Agency:**

All housing service referrals for unaccompanied youth and young adults must be screened and assessed at a centralized intake hotspot. The Lead Agency is responsible for overseeing and ensuring that:

- Unaccompanied youth and young adults willingly engage with coordinated intake for a screening and an in person comprehensive assessment.
- Whenever possible, unaccompanied youth should be re-housed within the catchment area of their school of origin.
- Low barriers of entry for this highly vulnerable population are created.
- Navigators consult with expert providers of this population when conducting intake to properly match clients and providers, and reduce the risk of flight for this highly vulnerable population.

## PROGRAM EVALUATION

Coordinated Intake and Assessment is one of many projects within our community that addresses the needs of individuals and families that are at risk or experiencing homelessness within our communities. The Lead Agency will evaluate the effectiveness as well as required HEARTH Act outcomes by utilizing data from HMIS. As recommended by the National Alliance to End Homelessness, the Lead Agency will track progress in the following areas to evaluate the Coordinated Intake and Assessment process:

- Length of stay, particularly in shelter: If consumers are referred to the right interventions and those interventions have the necessary capacity, fewer individuals and families should be staying in shelter waiting to move elsewhere. Also if clients are referred immediately to the right provider, over time, clients will likely spend less time jumping from program to program looking for help, which could reduce their overall length and/or repeated episodes of homelessness.
- New entries into homelessness: if every individual and family seeking assistance is coming through the front door to receive it and the front door has prevention and diversion resources available, more people should be able to access these resources and avoid entering a program unnecessarily.
- Repeat episodes of homelessness: If clients are sent to the intervention that is the best suited to meet their needs on the first time, families are more likely to remain stably housed.

To track the outcomes summarized above, the Lead Agency will analyze the following Performance Measures annually.

1) Duval, Nassau and Clay County will reduce the number of person experiencing homelessness.
    a. Reduction in the total number of person experiencing homelessness
    b. Reduction in the total number of persons experiencing first time homelessness.
2) Duval, Nassau and Clay County will reduce the length of homelessness episodes
    a. Reduction in the mean length of homelessness episode for individuals
    b. Reduction in the mean length of homelessness episode for families with children
    c. Reduction in the men length of homelessness episode for youth

3) Duval, Nassau and Clay County will reduce the number of persons returning to homelessness.
    a. Reduction in return to homelessness within two years following exit
    b. Increase in exits to permanent housing
    c. Increase in income at exit

Measuring of the success of this system and transparency with the community and providers will be a key to the success of this project. The Lead Agency will summarize the data annually in conjunction with the annual Point in Time homeless census data report.

Moving forward, the Lead Agency will expand the evaluation of outcomes by establishing mechanisms to monitor the quality of service through system-wide monitoring. For example, once a client enters shelter an assessment is to be completed within 72 hours. Procedures will be built into the monitoring system to determine how often this goal is met. This will allow for ongoing monitoring of the quality of services and how the program and Providers are able to follow through with this goal.

As part of the evaluation process, as recommended by the National Alliance to End Homelessness, the Lead Agency will set a goal to establish an integrated feedback loop that involves using information gained from these assessments to make any necessary adjustments to the system. For example, if families are being referred to the right program, but the program cannot serve them due to capacity issues while other program types have an increasing number of empty beds, it may be appropriate to make system-wide shifts in the types of programs and services offered. Additionally, the Lead Agency will continue working to develop data tools to ensure overall system efficiency and effectiveness.