

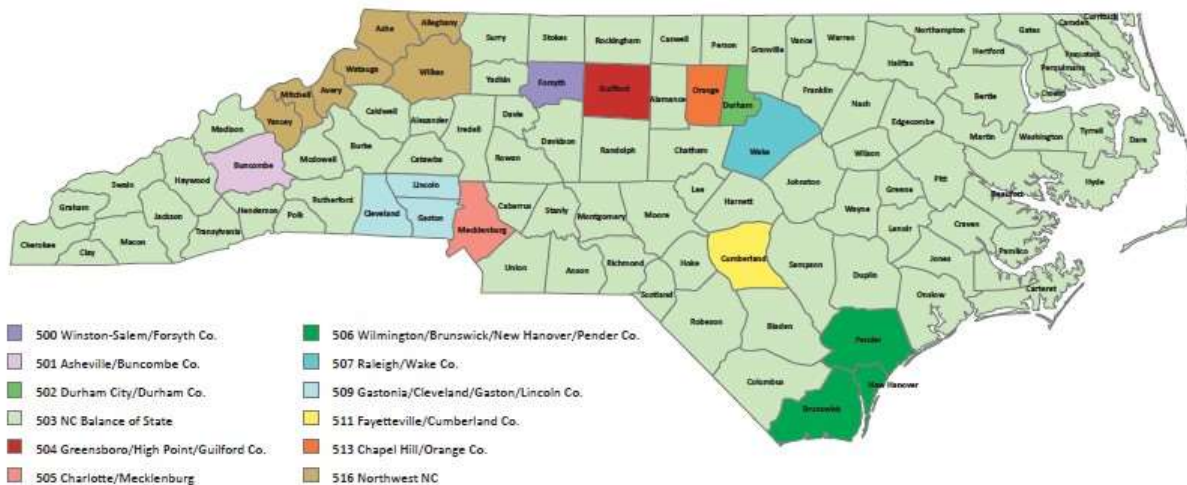
SECTION I. BACKGROUND

In 1995, the U.S. Department of Housing and Urban Development (HUD) originally developed the concept of a Continuum of Care (CoC). The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 says that a CoC “is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons to the extent these groups are represented within the geographic area and are available to participate.” The HEARTH Interim Rule states “a CoC is the coordinating body for homeless services and homelessness prevention activities across the geographic area.” (24 CFR Part 578)

The NC Balance of State Continuum of Care (NC BoS CoC) is one of 12 CoCs in North Carolina. NC BoS CoC includes 79 of North Carolina’s 100 counties.

NC BoS CoC counties: Alamance, Alexander, Anson, Beaufort, Bertie, Bladen, Burke, Cabarrus, Caldwell, Camden, Carteret, Caswell, Catawba, Chatham, Cherokee, Chowan, Clay, Columbus, Craven, Currituck, Dare, Davidson, Davie, Duplin, Edgecombe, Franklin, Gates, Graham, Granville, Greene, Halifax, Harnett, Haywood, Henderson, Hertford, Hoke, Hyde, Iredell, Jackson, Johnston, Jones, Lee, Lenoir, Macon, Madison, Martin, McDowell, Montgomery, Moore, Nash, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Person, Pitt, Polk, Randolph, Richmond, Robeson, Rockingham, Rowan, Rutherford, Sampson, Scotland, Stanly, Stokes, Surry, Swain, Transylvania, Tyrell, Union, Vance, Warren, Washington, Wayne, Wilson, and Yadkin.

North Carolina Continuum of Care (CoC) Primary Areas



NC BoS CoC was formed by the Interagency Council for Coordinating Homeless Programs (ICCHP) and submitted its first application as a CoC in 2006. The new NC BoS CoC included counties that were previously smaller CoCs and counties that had never before applied for CoC funding.

NC BoS CoC was initially coordinated through the NC Department of Health and Human Services (NC DHHS), which served as the Lead Agency and Collaborative Applicant for the NC BoS CoC. In 2009, NC DHHS contracted with the NC Coalition to End Homelessness (NCCEH) to coordinate the NC BoS CoC. In 2015, NCCEH became the Lead Agency and Collaborative Applicant.

SECTION II. PURPOSE

a. Vision

To ensure that individuals and families who become homeless return to permanent housing within 30 days.

b. Mission

The North Carolina Balance of State Continuum of Care, composed of a 79-county region, uses evidence-based strategies to implement solutions to prevent and end homelessness in the most efficient, effective, and ethical manner.

c. Overall

NC BoS CoC coordinates and implements a comprehensive system to address homeless issues in its 79-county area. As a CoC, the NC BoS CoC is responsible for four main areas:

1. Administering NC BoS CoC governance and working committees
2. Submitting funding applications
3. Coordinating data collection and assessment
4. Planning for the future of the CoC

SECTION III. COMMITTEE STRUCTURE

a. NC BoS CoC Steering Committee

1. Purpose

The NC BoS CoC Steering Committee serves as the primary decision-making body and board for NC BoS CoC. The Steering Committee is responsible for all matters pertaining to the structure, purpose, performance, and activities of the NC BoS CoC.

2. Structure

Steering Committee membership is composed of Regional Committee seats and at-large seats.

Each Regional Committee elects one Regional Lead who serves on the Steering Committee. The Regional Committee should also elect an alternate to fill in for the Regional Lead in the event of their absence or a conflict of interest.

In 2017, a Steering Committee restructuring proposal, drafted by a workgroup and approved by the Steering Committee, added at-large seats, which do not directly represent any single Regional Committee. The Steering Committee must have at least 7 and may have as many as 13 at-large members. At-large members are elected by the other members of the Steering Committee in December. At-large member terms are one year, starting in January.

At-large seats are allocated across three categories, as follows:

- Category 1: People with lived experience of homelessness. Minimum 1 seat, maximum 2 seats. Representatives in this category cannot also occupy another seat on the Steering Committee (people holding other seats on the Steering Committee may also have lived experience of homelessness).
- Category 2: North Carolina State Government. Minimum 3 seats, maximum 6 seats. Representatives should be from the following departments and work with or oversee a program that serves people experiencing homelessness:
 - Department of Health and Human Services
 - Department of Public Safety
 - Housing Finance Agency
 - Department of Education
 - Department of Military and Veteran Affairs
 - Department of Commerce
- Category 3: Other at-large seats. Minimum 3 seats, maximum 5 seats. Representatives should be from the following sectors:
 - Health care sector, ideally with a state-wide focus
 - Business sector, ideally with a state-wide focus
 - Public housing agency
 - Domestic violence services or advocacy sector, ideally with a state-wide focus
 - Legal services
 - Youth services or advocacy sector, ideally with a state-wide focus

The Steering Committee meets monthly, normally via conference call and at least one time per year in person. All meetings are public meetings, open to any interested party. Meeting agendas and minutes are posted on the internet in a timely manner. This process was formally established by NC BoS CoC in August 2013, reviewed in Fall 2017, and will be reviewed again within five years.

3. Roles & Responsibilities

The Steering Committee is staffed and led by NCCEH.

The Steering Committee is responsible for:

- Promoting a community-wide commitment to the goal of ending homelessness
- Providing funding for efforts to quickly rehouse homeless individuals (including unaccompanied youth) and families, while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by their experience with homelessness
- Promoting access to and effective utilization of mainstream programs by homeless individuals and families
- Providing direction on funding priorities and project application review criteria
- Creating a network of providers for:
 - Outreach, engagement, & assessment
 - Shelter, permanent housing, & supportive services for persons experiencing a housing crisis
 - Homelessness prevention services
- Consulting with recipients of Emergency Solutions Grants funds regarding:
 - Allocation of funds
 - Reporting & evaluating performance
- Monitoring recipient and subrecipient performance, evaluating outcomes, and taking action against poor performers
- Establishing performance targets appropriate for population and program type in consultation with recipients and subrecipients
- Reviewing and approving significant change requests from CoC grantees in accordance with the significant change policy (see APPENDIX 5)
- Establishing and operating a coordinated entry system, in consultation with the recipients of Emergency Solutions Grant's program funds
- Establishing and consistently following written standards for providing CoC assistance, in consultation with the recipients of Emergency Solutions Grant's program funds

Regional Leads are responsible for:

- Representing their Regional Committees in all matters pertaining to NC BoS CoC.
- Regularly attending monthly Steering Committee and other NC BoS CoC meetings. Regional Leads, or their official designated alternates or stand-ins, must attend at least 75% of Steering Committee meetings in order for their Regional Committee to be eligible to apply for CoC funds. If the Regional Lead or official alternate are unable to attend the meeting, the Regional Lead should email NCCEH with contact information for a stand-in attendee.

At-large Steering Committee members are responsible for:

- Using their expertise to help the NC BoS CoC make better decisions and improve the response to homelessness.
- Helping to improve coordination between the CoC and the member's agency/sector.
- Attending at least 75% of Steering Committee meetings.

4. Avoiding Conflict of Interest

In order to maintain high ethical standards, HUD requires Steering Committee members (Regional Leads/alternates and at-large members) to comply with Conflict of Interest requirements. Steering Committee members may not participate in or influence any discussions or decision regarding an award of financial benefit to an organization that s/he represents. Steering Committee members complete and sign a Conflict of Interest Information Form (APPENDIX 2) each year with updated information about organizations that s/he represents as an employee, donor, volunteer, member, board member, trustee, or any other affiliation.

5. Voting & Quorums

Each Steering Committee member (Regional Leads/alternates and at-large members) gets one vote in voting matters. Regional Leads and at-large members can vote, make motions, and second motions on matters before the Steering Committee. Officially elected alternates can also vote, make or second motions for the Regional Committee if the Regional Lead is not present or recuses him/herself. In the case a Regional Lead is also the alternate for a second Regional Committee and needs to register a vote, this person will get a vote for each Regional Committee.

Officially elected alternates count for Steering Committee attendance and towards reaching a quorum in the absence of the Regional Lead. In the event that the Regional Lead or the alternate cannot represent their Regional Committee at a Steering Committee meeting, another person may attend as a stand-in and count for Steering Committee attendance but cannot make or second motions or vote for the Regional Committee if the Regional Lead or alternate is not present or recuses him/herself. Stand-ins do not count towards reaching a quorum.

A quorum within the Steering Committee membership must be present to hold a vote at regular Steering Committee meetings. A quorum is the minimum number of eligible voting members (51%). According to Robert's Rules of Order Newly Revised, Tenth Edition, the "requirement for a quorum is protection against totally unrepresentative action in the name of the body by an unduly small number of persons." If a quorum is not present, votes cannot be conducted. Subcommittee meetings and workgroups do not require a quorum.

b. Regional Committees

1. Purpose

NC BoS CoC is broken down into local Regional Committees, which represent the totality of homeless services and providers in a given area. Regional Committees serve as a community resource for coordination and networking on the local level.

2. Structure

In June 2016, the NC BoS CoC Steering Committee approved a proposal to restructure Regional Committees from 26 committees to 13. The restructuring process occurred from June through

December 2016, with new Regional Committees in place as of January 1, 2017. Please find a list and map of the 13 NC BoS CoC Regional Committees in APPENDIX 3.

All Regional Committees of NC BoS CoC must:

- Have a regular meeting time and place(s)
- Publish notices of their meeting agendas and minutes and open meetings to any interested party
- Post meeting agendas and minutes to the NCCEH website on a timely basis
- Have participation from a large variety of providers, stakeholders, and subpopulations from each county within the physical bounds of the Regional Committee
- Design coordinated entry systems within parameters set forth in the NC BoS CoC Coordinated Entry written standards
- Administer coordinated entry systems
- Annually elect a Regional Lead and alternate to represent the Regional Committee on the NC BoS CoC Steering Committee
- Elect leadership positions as outlined below

3. Roles & Responsibilities

Regional Committees are responsible for annually electing the leadership positions listed below. These positions serve one-year terms beginning January 1, and elections should be held in the fourth quarter prior to this start date. Each agency should be limited to no more than 2 leadership positions per region. Special approval may be granted by NCCEH staff and voted on by the NC BoS CoC Steering Committee to allow an agency to serve in more than 2 leaderships positions per region. Elections must be reflected in Regional Committee meeting minutes.

- A Regional Lead to the Steering Committee (more on this above, Section V.(a) NC BoS CoC Steering Committee)
- An alternate lead
- One representative to the CoC Scorecard Committee
- One representative to the CoC Project Review Committee (keeping in mind conflict of interest restrictions, *i.e.*, that a member of this committee cannot also represent an agency applying for funding)
- A coordinated entry lead
- A Point-in-Time Count lead
- A funding committee lead, who will oversee the ESG application process and ensure the Regional Committee is involved in CoC funding committees
- A webmaster, who is responsible for posting meeting minutes to the NCCEH website
- Representatives to working groups as necessary

NC BoS CoC Regional Committees must also provide accurate and complete information on an annual basis, including:

- Point-in-Time population count and bed inventory from each member agency
- Listing of member agencies and services provided
- Information needed to complete the CoC application to HUD

Regional Committees encourage broad-based community stakeholder participation in their meetings. They also promote data quality among their members to include submitting timely and accurate:

- Annual Performance Reports (APRs) to HUD
- High-quality data within NC HMIS

Regional Committees are also responsible for:

- Coordinating the region's Emergency Solutions Grants funding process
- Encouraging Regional Committee members to participate in NC BoS CoC subcommittees
- Coordinating local temporary and permanent housing, services, and other resources
- Ensuring adequate HMIS bed coverage
- Supporting priorities set by the NC BoS CoC Steering Committee

c. Subcommittees

1. Purpose

The Steering Committee currently has two standing subcommittees which are open to any interested party. The subcommittees review performance measures, assess progress, and discuss best practices.

Veterans Subcommittee

- Meets bi-monthly
- Implements CoC-wide plan to end Veteran homelessness
- Oversees regional Veteran plans

Funding and Performance Subcommittee

- Meeting schedule determined by subcommittee members
- Analyzes relevant data including, but not limited to, system performance measures, progress toward ending homelessness among subpopulations, and resource allocation
- Assists the Steering Committee to set goals and priorities for the CoC and to make funding decisions

Nominating Subcommittee

- Meeting schedule determined by subcommittee members. Meetings will be held in the fourth quarter of the calendar year.
- Determines which at-large members to extend an invitation to renew for an additional year on the Steering Committee.
- Recommends candidates to serve as at-large members on the Steering

Committee.

d. Funding Application Committees

The Steering Committee currently has two standing subcommittees that inform the CoC's funding decisions. These committees meet on an as-needed basis.

1. Scorecard Committee

- Composed of one representative from each NC BoS CoC Regional Committee and at-large Steering Committee members up to but not exceeding the number of Regional Committee representatives
- Determines criteria and scoring guidelines for new and renewal project scorecards

2. Project Review Committee

- Composed of one representative from each NC BoS CoC Regional Committee and at-large Steering Committee members up to but not exceeding the number of Regional Committee representatives (members cannot be from agencies applying for funding)
- Regional Committees should elect their Project Review Committee Representative during their fourth quarter leadership elections.
- Reviews and rates each project application according to the current scorecard
- Recommends ranked list of project applications for CoC collaborative application to the Steering Committee
- Reviews application materials for agencies applying for projects being transferred from existing CoC grantees and provides recommendation for Steering Committee approval.

e. Coordinated Entry Council

The Steering Committee appoints a standing Coordinated Entry Council to review, provide feedback on, and ultimately recommend approval of coordinated entry plans written by Regional Committees. The Coordinated Entry Council provides oversight for Regional Committees implementing coordinated entry by reviewing plan changes and system outcomes, providing support and feedback, and hearing grievances that cannot be resolved at the local level. The Coordinated Entry Council is made up of all elected Regional Committee Coordinated Entry Leads and other state-level experts.

f. Working Groups

The Steering Committee forms short-term, outcome-focused working groups on an as-needed basis. The scope of work and proposed group duration will be determined by the Steering Committee. Working group membership will vary depending on the particular needs of the group, but generally should represent the totality of the Steering Committee (region, subpopulation, etc.) as feasible.

SECTION IV. FUNDING APPLICATIONS

The NC BoS CoC is responsible for preparing and overseeing the application process for HUD CoC grants (applied to HUD by CoC) and HUD ESG grants (applied to NC DHHS by Regional Committees). The NC BoS CoC does this by establishing funding priorities via a transparent and inclusive process and designing, operating, and following a collaborative process. The NC BoS CoC encourages all eligible applicants to submit project applications.

a. CoC Grants

NCCEH is the designated collaborative applicant that submits the CoC grant application and manages the application process at the CoC-level. NC BoS CoC Steering Committee, staff, project applicants, and funding application committees work together to prepare and submit the collaborative application. Project applicants are responsible for individual project applications. Each year the application timeline is contingent on HUD.

b. ESG Grants

HUD provides block grant funds to each state for the Emergency Solutions Grants program (hereafter ESG). The State of North Carolina, through DHHS, Division of Aging and Adult Services, Adult Services Section determines and distributes ESG money to each CoC in North Carolina and to Regional Committees within the NC BoS CoC. Regional Committees manage the project application process for ESG with oversight from NC BoS CoC staff. The NC BoS CoC has the authority to review and approve ESG applications.

SECTION V. DATA COLLECTION & ASSESSMENT

a. HMIS

NC BoS CoC is a part of a shared regional HMIS with NC-502 Durham City/Durham County CoC and NC-513 Chapel Hill/Orange CoC, and a member of the HMIS Advisory Board. As such NC BoS CoC has four primary responsibilities:

1. **Designate an HMIS Lead Agency:** At the recommendation of the HMIS Advisory Board, the NC BoS CoC Steering Committee shall approve an HMIS Lead Agency to operate the regional HMIS. This entity will be responsible for ensuring that all applicable federal partner regulations and notice requirements are met.
2. **Designate an HMIS Grantee:** The NC BoS CoC Steering Committee shall designate an HMIS grantee who will be the single agency to manage HMIS funding and ensure all financial obligations are met.
3. **Designate HMIS Advisory Board Representatives:** The NC BoS CoC Steering Committee shall designate two representatives from the Continuum of Care to the HMIS Advisory Board.
4. **Review HMIS Advisory Board Governance Charter:** The HMIS Advisory Board Governance Charter directs the governance of the regional HMIS. NC BoS CoC

may approve or send suggestions to the HMIS Advisory Board on amendments for adoption.

5. **Role of NC BoS CoC staff:** NC BoS CoC staff, in partnership with the HMIS Advisory Board, shall ensure the following:
- Consistent participation in HMIS for all federal partner-funded programs and encourage the same for all other agencies
 - For agencies that are exempt from participating in HMIS by federal statute (for example, domestic violence service providers), NC BoS CoC staff will support participation in a comparable database that meets HUD standards for HMIS
 - HMIS is administered within NC BoS CoC in compliance with requirements prescribed by HUD
 - Oversight is provided by the HMIS Advisory Board
 - Compliance with all HUD rules and regulations, including reviewing, revising, and approving three key data documents: a privacy plan, a security plan, and a data quality plan

NC BoS CoC uses CoC program funds for an HMIS grant to fund the CoC's HMIS.

b. Point-in-Time Count

NC BoS CoC plans and conducts an annual Point-in-Time Count (PIT) that counts and collects data on homeless people who are both unsheltered and sheltered within emergency shelters and transitional housing. NC BoS CoC will provide training, forms, and instruction for Regional Committees on conducting this count. Normally, the PIT is held on the last Wednesday in January. The PIT will comply with any additional HUD requirements.

c. Housing Inventory Chart (HIC)

NC BoS CoC completes the annual Housing Inventory Chart (HIC), which includes a bed inventory of all emergency shelters, transitional housing programs, rapid re-housing programs, and permanent supportive housing programs in the CoC, as well as the CoC's Point-in-Time Count data. The HIC is submitted to HUD through the Homeless Data Exchange in accordance with the deadline set by HUD.

d. Longitudinal System Analysis (LSA)

In conjunction with the HMIS Lead Agency, NC BoS CoC completes the Longitudinal System Analysis report, which includes both point-in-time and annual HMIS data on homeless clients enrolled in the CoC's emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing programs. The LSA data is submitted to HUD through the Homeless Data Exchange in accordance with the deadline set by HUD. The data is then used by HUD to generate the Annual Homeless Assessment Report to Congress.

SECTION VI. STAFF ROLES

The NC BoS CoC is staffed by the NC Coalition to End Homelessness. NC BoS CoC staff is responsible for:

a. CoC Coordination

- Coordinate and staff NC BoS CoC Steering Committee
- Provide technical support and capacity-building to local NC BoS CoC communities, project applicants, and CoC and ESG grantees
- Manage NC BoS CoC website, email lists, and other communications
- Coordinate and facilitate subcommittee meetings (see above Section II. (c) Subcommittees)
- Coordinate NC BoS CoC approval process for regional ESG applications
- Organize and staff workgroups as needed for time-limited projects
- Staff the Coordinated Entry Council (CEC)
- Support the HMIS implementation (see above Section V. (a) 5. HMIS)

b. CoC Application Preparation

- Prepare and validate Grant Inventory Worksheet and complete the CoC registration process
- Assist new and renewal applicants in completing CoC project applications by providing technical assistance and feedback
- Coordinate scoring and ranking of applications
- Complete and submit CoC collaborative application
- Submit LSA data
- Collaborate with NC BoS CoC Regional Committees to gather and compile Point-in-Time (PIT) and Housing Inventory Chart (HIC) data. Complete the HIC and submit with PIT to HUD Homeless Data Exchange.

c. Written Standards

The NC BoS CoC Steering Committee approved a comprehensive set of written standards for all CoC- and ESG-funded programs and for the NC BoS CoC coordinated entry system on September 6, 2016 (see APPENDIX 4: WRITTEN STANDARDS). Updated Coordinated Entry written standards that reflect HUD Notice CPD-17-01 were approved by the Steering Committee on September 5, 2017. Street Outreach Written Standards were approved by the Steering Committee on April 3, 2018.

SECTION VII. GOVERNANCE CHARTER

a. Ratification

The NC BoS CoC Governance Charter was formally adopted by the Steering Committee on August 6, 2013 and most recently amended on June 5, 2018. The Charter may be thereafter amended at a regular Steering Committee meeting by a simple majority (at least 51%) affirmative vote of the members present and determined eligible to vote.

b. Process for Amending the Charter

Proposed amendments must be in written form and distributed to Steering Committee members prior to the presentation and vote. The Governance Charter may be fully revised to include agreed-upon changes, or an Amended Article may be added for

insertion into the existing document.

c. Annual Renewal & Updates

NC BoS CoC Steering Committee will formally review and update the NC BoS CoC Charter annually, making changes as necessary.

APPENDIX 1: ABBREVIATIONS

AHAR	Annual Homeless Assessment Report
APR	Annual Performance Report
BoS	Balance of State
CE	Coordinated Entry
CoC	Continuum of Care
ESG	Emergency Solutions Grant (formerly Emergency Shelter Grant)
HEARTH	Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009
HIC	Housing Inventory Chart
HMIS	Homeless Management Information System
HUD	Federal Department of Housing and Urban Development
ICCHP	Interagency Council for Coordinating Homeless Programs
LSA	Longitudinal System Analysis
NC BoS CoC	North Carolina Balance of State Continuum of Care
NC DHHS	North Carolina Department of Health and Human Services
NCCEH	North Carolina Coalition to End Homelessness
NOFA	Notice of Funding Availability
PIT	Point-in-Time Count
PSH	Permanent Supportive Housing
RRH	Rapid Re-housing

APPENDIX 2: CONFLICT OF INTEREST FORM

North Carolina Balance of State Continuum of Care

bos@ncceh.org

919.755.4393

www.ncceh.org/BoS

NC BoS Steering Committee Conflict of Interest Policy & Disclosure Form

Policy

The standard of behavior at the North Carolina Balance of State (NC BoS) Continuum of Care is that all staff and Steering Committee members scrupulously avoid any conflict between their personal, professional, and business interests and the interests of NC BoS. This includes avoiding actual conflicts of interest as well as perceptions of conflicts of interest.

The purposes of this policy are to:

- comply with the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the Continuum of Care Program, Interim Final Rule (24 CFR Part 578),
- protect the integrity of NC BoS Steering Committee's decision-making process,
- enable our constituencies to have confidence in our integrity, and
- safeguard the integrity and reputation of Steering Committee members.

Upon election to the NC BoS Steering Committee, members submit a full written disclosure of their interests, relationships, and holdings that could potentially result in a conflict of interest. This written disclosure will be kept on file and updated annually.

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 requires NC BoS CoC Steering Committee members to disclose any conflicts of interests that arise in the course of meetings or activities. These include transactions, discussions or decisions in which members (or their business or other nonprofit affiliations), their families and/or significant others, employers, or close associates will receive a benefit or gain. Members also disclose any family relationship, either by consanguinity or marriage, between themselves and an agent or employee of NC BoS who will be directly affected by a transaction or decision. After disclosure, members recuse themselves from participating in the transaction, discussion or decision.

This policy is meant to be a supplement to good judgment – Steering Committee members will respect its spirit as well as its wording.

APPENDIX 2: CONFLICT OF INTEREST FORM, CONT.

Disclosure Form

Personal Data
Name:
Current Employer or Business Affiliation:
Position:
Other Business Activities
Please disclose any other employment, business, or financial interest which you or a member of your immediate family may have as an officer, director, trustee, partner, employee, or agent which might give a rise to a possible conflict of interest with NC BoS.
Charitable or Civic Involvement
Please disclose all official positions which you or any member of your immediate family may have as a director, trustee, or officer of any charitable, civic, or community organization as well as any unofficial roles such as significant donor, volunteer, advocate, or advisor which might give rise to a possible conflict of interest with NC BoS.
REMINDER: <i>If at any time there is a matter under consideration that may constitute a direct or indirect conflict of interest not listed on this form, it is your obligation to disclose the facts to the Steering Committee.</i>

I do hereby affirm that I have received and read the policy and I will adhere to the document's spirit, principles, and practices.

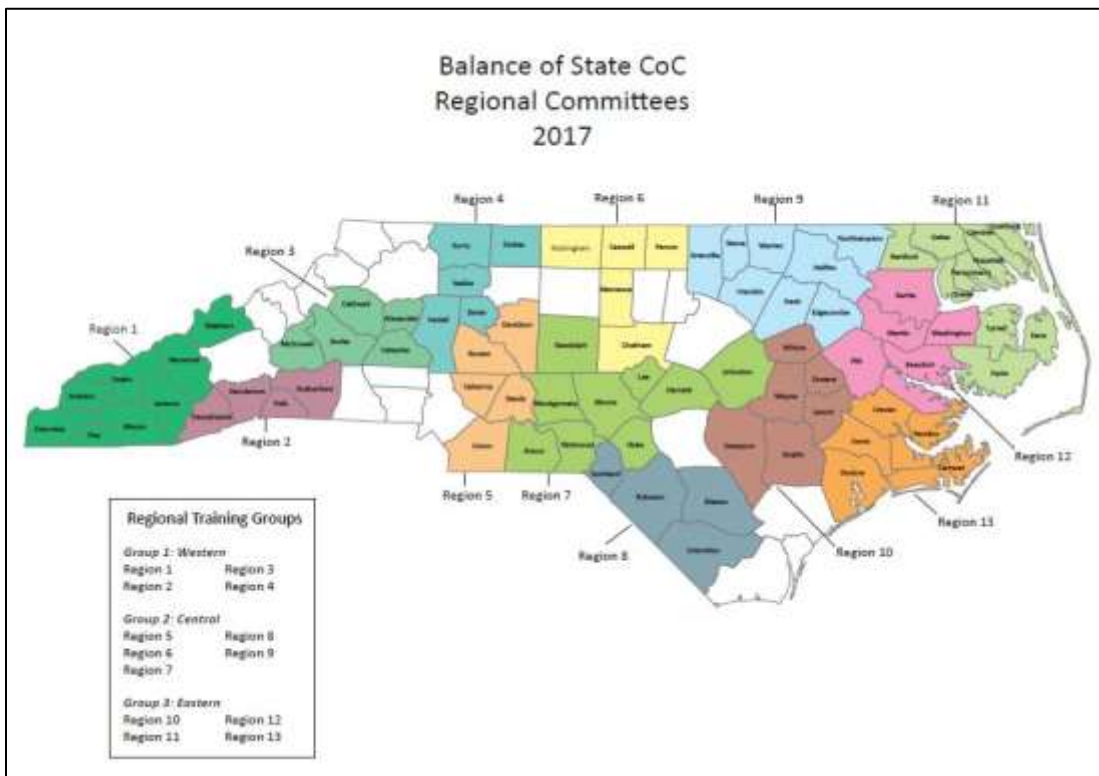
Signature

Date

APPENDIX 3: LIST & MAP OF REGIONAL COMMITTEES

List of Regional Committees, effective January 1, 2017

- Region 1: Cherokee, Clay, Graham, Swain, Macon, Jackson, Haywood, Madison
- Region 2: Transylvania, Henderson, Polk, Rutherford
- Region 3: McDowell, Burke, Caldwell, Catawba, Alexander
- Region 4: Surry, Stokes, Yadkin, Iredell, Davie
- Region 5: Davidson, Rowan, Cabarrus, Stanly, Union
- Region 6: Rockingham, Caswell, Person, Alamance, Chatham
- Region 7: Randolph, Montgomery, Anson, Richmond, Moore, Hoke, Lee, Harnett, Johnston
- Region 8: Scotland, Robeson, Bladen, Columbus
- Region 9: Granville, Vance, Franklin, Warren, Halifax, Nash, Edgecombe, Northampton
- Region 10: Wilson, Greene, Wayne, Lenoir, Sampson, Duplin
- Region 11: Hertford, Gates, Chowan, Perquimans, Pasquotank, Camden, Currituck, Tyrrell, Dare, Hyde
- Region 12: Bertie, Martin, Washington, Pitt, Beaufort
- Region 13: Craven, Jones, Pamlico, Onslow, Carteret



APPENDIX 4: WRITTEN STANDARDS

NC Balance of State Continuum of Care Program Standards Emergency Shelter

OVERVIEW

The NC Balance of State Continuum of Care has developed these program standards to provide specific guidelines for how programs can operate to have the best chance of ending homelessness. These guidelines create consistency across the Balance of State, protect our clients by putting their needs first, and provide a baseline for holding all CoC programs to a specific standard of care.

The Department of Housing and Urban Development (HUD) requires every Continuum of Care to evaluate outcomes of projects funded under the Emergency Solutions Grants program and the Continuum of Care program and report to HUD (24 CFR 578.7(a)7). In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individual and families for housing and services.

In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and consistently follow written standards for providing CoC assistance. At a minimum, these standards must include:

- Policies and procedures for evaluating individuals' and families' eligibility and determining the process for prioritizing eligible households in emergency shelter, transitional housing, rapid rehousing, and permanent supportive housing programs (24 CFR 578.7(a)(9)).
- Program standards that meet HUD's requirements for emergency shelters to define policies and procedures for admission, diversion, referral, and discharge standards as well as safeguards to meet needs for special populations such as victims of domestic violence, dating violence, sexual assault, and stalking.
- Policies and procedures for coordination among emergency shelters, transitional housing programs, essential service providers, Homelessness Prevention programs, Rapid Rehousing programs, and Permanent Supportive Housing programs.
- Definitions for participation in the CoC's Homelessness Management Information System (or comparable database for domestic violence or victims' service programs).

The Balance of State Continuum of Care developed the following Emergency Shelter program standards to ensure:

- Program accountability to individuals and families experiencing homelessness, specifically populations at greater risk or with the longest histories of homelessness
- Program compliance with the Department of Housing and Urban Development
- Service consistency within programs
- Adequate program staff competence and training, specific to the target population served

EXPECTATIONS

All program grantees using Department of Housing and Urban Development Continuum of Care and Emergency Solutions Grant funding must adhere to these performance standards and will be monitored by the Balance of State Continuum of Care to ensure compliance. The BoS CoC recommends that emergency shelters funded through other sources also follow these standards. These performance standards attempt to provide a high standard of care that places community and client needs first. Based on proven best practices, this high standard of care is necessary to achieve our goal of ending homelessness in the BoS CoC.

EMERGENCY SHELTER

Emergency shelter is any facility whose primary purpose is to provide temporary housing for individuals or families experiencing homelessness for a period of 90 days or less¹. Emergency shelters, as we know them today, emerged during the late 1970s and early 1980s in response to an increasing number of individuals experiencing homelessness. These initial shelters were meant to provide a short-term emergency stay for individuals as they rehoused themselves. However, because of decreased affordable housing in urban centers, a lack of substantive supportive services catering to the needs of homeless individuals, and a large subpopulation of individuals with disabling conditions, the movement out of emergency shelter into permanent housing stalled with many individuals staying in shelter for long periods of time.

With the advent of permanent supportive housing and rapid rehousing based on the national best practice, Housing First, communities are moving some of their most vulnerable homeless individuals and families with the longest histories of homelessness into permanent housing. This allows the emergency shelter system to regain its original intention, providing individuals experiencing homelessness a temporary stay until they can regain permanent housing.

Emergency shelters serve a wide variety of people experiencing homelessness in our communities and may target their services to a particular type of population. Many emergency shelters serve a single gender, individuals and/or families, people fleeing domestic violence, or a combination thereof. The most effective emergency shelters direct their services and resources toward a truly interim housing solution and have strong connections to permanent housing programs catering to the needs of people experiencing homelessness. Emergency shelters can provide short-term housing for individuals and families waiting for placement in a rapid rehousing program or permanent supportive housing program.

In the NC Balance of State Continuum of Care shelters can help reduce the number of unsheltered individuals and families in their communities by reducing barriers in their programs and accepting high-need individuals or families. However, this is where emergency shelters can play a significant role in the Balance of State's efforts to end homelessness as we know it. Emergency shelters should provide triage and interim beds for high-need and chronically homeless individuals and families while they partner with permanent housing programs to place participants.

Emergency shelters should operate from a Housing First philosophy. Programs with a Housing First approach believe that anyone can be housed and the barriers to permanent housing can be

¹ <https://www.gpo.gov/fdsys/granule/CFR-2012-title24-vol3/CFR-2012-title24-vol3-part576/content-detail.html>

minimized. Housing First allows emergency shelters to move individuals and families experiencing homelessness more quickly from their shelter beds into permanent housing, thus meeting the main objective of emergency shelter.²

Every emergency shelter program should participate in the local community's coordinated assessment system, including the Balance of State prioritization of individuals for housing. In the Balance of State, each community utilizes the Prevention and Diversion screening tool and the Individual and Family VI-SPDAT Prescreen Tools to set priorities and housing triage methods, while housing programs use the Case Management Tool for more developed housing placement purposes and for intensive case management over time. The Prevention and Diversion screening tool prioritizes shelter beds for people who have no other safe housing option and should be administered to every household who presents needing shelter prior to being admitted into a shelter program. Communities use the VI-SPDAT to prioritize individuals and families experiencing literal homelessness based on an acuity score that indicates the type of housing intervention best suited to their ongoing needs.

DEFINITIONS

Acuity: When using the VI-SPDAT prescreens, acuity means the presence of a presenting issue based on the prescreening score. Acuity on the prescreening tool is expressed as a number with the higher score representing more complex, co-occurring issues likely to impact overall stability in permanent housing. When using the Case Management Tool, acuity refers to the severity of the presenting issue and the ongoing goals in addressing these issues.

Case Management Tool: A standardized tool for case management to track outcomes in the coordinated assessment process. Housing programs administer this tool at program entry, housing entry, and every six months thereafter until program discharge. Upon discharge from the program, housing case managers administer the tool one final time 12 months later, when possible, to ensure the household continues to make progress.

Chronically Homeless: (1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) has been homeless and living as described in (i) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; (2) an individual who has been residing in an institutional care facility, including jail, substance abuse, or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) a family with an adult head of household (or if there is not adult in the family, a minor head of household) who meets all of the criteria in (1) or (2) of this definition, including a family whose composition had fluctuated while

² http://www.endhomelessness.org/page/-/files/4.2_Housing-Focused_Emergency_Shelter_-_Ralph_Payton.pdf

the head of homelessness has been homeless. (24 CFR 578.3)

Comparable Database: HUD-funded providers of housing and services (recipients of ESG and/or CoC funding) who cannot enter information by law into HMIS (victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database comparable to HMIS. According to HUD, “a comparable database . . . collects client-level data over time and generates unduplicated aggregate reports based on the data.” The recipient or subrecipient of CoC and ESG funds may use a portion of those funds to establish and operate a comparable database that complies with HUD’s HMIS requirements. (24 CFR 578.57)

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Disabling Condition: According to HUD: (1) a condition that: (i) is expected to be of indefinite duration; (ii) substantially impedes the individual’s ability to live independently; (iii) could be improved by providing more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or a developmental disability, as defined above; or the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from AIDS, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5)

Diversion: Diversion is a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion practices and programs help reduce the number of people

becoming homeless and the demand for shelter beds.

Family: A family includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) a single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or (2) a group of persons residing together, and such group includes, but is not limited to: (i) a family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) an elderly family; (iii) a near-elderly family; (iv) a disabled family; (v) a displaced family; and (vi) the remaining member of a tenant family. (24 CFR 5.403)

Homeless: *Category 1:* an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals); or (iii) an individual who exits an institution where he/she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

Category 2: an individual or family who will immediately lose their primary nighttime residence, provided that: (i) the primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) no subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing; or

Category 4: any individual or family who: (i) is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence; (ii) had no other residence; and (iii) lacks the resources or support networks (e.g. family, friends, and faith-based or other social networks) to obtain other permanent housing. (24 CFR 578.3)

Housing First: A national best practice model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment compliance, and service and/or income requirements. Programs offer supportive services to maximize housing stability to prevent returns to homelessness rather than meeting arbitrary benchmarks prior to permanent housing entry.³

Prevention and Diversion Screening Tool: A tool used to reduce entries into the homeless service system by determining a household's needs upon initial presentation to shelter or other emergency response organization. This screening tool gives programs a chance to divert households by assisting them to identify other permanent housing options and, if needed,

³ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf>

providing access to mediation and financial assistance to remain in housing.

Rapid Rehousing: A national best practice model designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve long-term stability. Like Housing First, rapid rehousing assistance does not require adherence to preconditions such as employment, income, absence of criminal record, or sobriety. Financial assistance and housing stabilization services match the specific needs of the household. The core components of rapid rehousing are housing identification/relocation, short- and/or medium-term rental and other financial assistance, and case management and housing stabilization services. (24 CFR 576.2)

Transitional Housing: Temporary housing for participants who have signed a lease or occupancy agreement with the purpose to transition households experiencing homelessness into permanent housing within 24 months.

VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool): An evidence-based tool used by all regions in the Balance of State to determine initial acuity and set prioritization and intervention for permanent housing placement.

PERFORMANCE STANDARDS

PERSONNEL

STANDARD: The program shall adequately staff services with qualified personnel to ensure quality of service delivery, effective program administration, and the safety of program participants.

Benchmarks

- The organization selects employees and/or volunteers with adequate and appropriate knowledge, experience, and stability for working with individuals and families experiencing homelessness and/or other issues that place individuals and families at risk of homelessness.
- The organization provides time for all employees and/or volunteers to attend webinars and/or trainings on program requirements, compliance and best practices.
- The organization trains all employees and/or volunteers on program policies and procedures, available local resources, and specific skill areas relevant to assisting clients in the program.
- For programs using the Homeless Management Information System (HMIS), all end users must abide by the HMIS User and Participation Agreements, including adherence to the strict privacy and confidentiality policies.
- Staff supervisors of casework, counseling and/or case management services have, at a minimum, a bachelor's degree in a human service-related field and/or experience working with individuals and families experiencing homelessness and/or other issues that place individuals and families at risk of homelessness.
- Staff supervising overall program operations have, at a minimum, a bachelor's degree in a human service-related field and/or demonstrated ability and experience that qualifies them to assume such responsibility.
- All program staff have written job descriptions that address tasks staff must perform and the minimum qualifications for the position.

- If the shelter provides case management as part of its programs, case managers provide case management with the designated Case Management Tool⁴ on a frequent basis (every six months minimum) for all clients.
- Organizations should share and train all program staff on the NC Balance of State Emergency Shelter Written Standards.

CLIENT INTAKE PROCESS

STANDARD: Programs will actively participate in their community's coordinated assessment system. Programs will serve the most vulnerable individuals and families needing assistance.

Benchmarks

- All adult program participants must meet the following program eligibility requirements in ESG-funded emergency shelter:
 - 18 years or older
 - Literally homeless, imminently at-risk of homelessness, and/or fleeing or attempting to flee domestic violence (see definitions listed above for Category 1, 2, and 4 of the homeless definition)
- All ESG recipients must use the standard order of priority for documenting evidence to determine homeless status and chronically homeless status. Grantees must document in the client file that the agency attempted to obtain the documentation in the preferred order. The order should be as follows:
 - Third-party documentation (including HMIS)
 - Intake worker observations through outreach and visual assessment
 - Self-certification of the person receiving assistance
- Programs can only turn away individuals and families experiencing homelessness from program entry for the following reasons:
 - Household makeup (provided it does not violate HUD's Fair Housing and Equal Opportunity requirements): singles-only programs can disqualify households with children; families-only programs can disqualify single individuals
 - All program beds are full
 - If the program has in residence at least one family with a child under the age of 18, the program may exclude registered sex offenders and persons with a criminal record that includes a violent crime from the program so long as the child resides in the same housing facility (24 CFR 578.93)
- Programs cannot disqualify an individual or family from entry because of employment status or lack of income.
- Programs cannot disqualify an individual or family because of evictions or poor rental history.
- Programs may make services available and encourage adult household members to participate in program services, but cannot make service usage a requirement to deny initial or ongoing services.
- Programs will maintain release of information, case notes, and all pertinent demographic and identifying data in HMIS as allowable by program type. Paper files should be maintained in a

⁴ CM Tool: <http://www.ncceh.org/files/6600/>; CM Tool Training: https://prezi.com/adwfk2xzig_/case-management-tool-version-2/

locked cabinet behind a locked door with access strictly reserved for case workers and administrators who need said information.

- Programs may deny entry or terminate services for program specific violations relating to safety and security of program staff and participants.

EMERGENCY SHELTER

STANDARD: Shelters will provide safe, temporary housing options that meet participant needs in accordance within guidelines set by the Department of Housing and Urban Development.

Benchmarks

- Shelters must meet state or local government safety, sanitation, and privacy standards. Shelters should be structurally sound to protect residents from the elements and not pose any threat to health and safety of the residents.
- Shelters must be accessible in accordance with Section 504 of the Rehabilitation Act, the Fair Housing Act, and Title II of the Americans with Disabilities Act, where applicable.
- Shelters may provide case management, counseling, housing planning, child care, education services, employment assistance and job training, outpatient health services, legal services, life skills training, mental health services, substance abuse treatment, transportation, and services for special populations per 24 CFR 576.102 but cannot deny shelter services to individuals and families unwilling to participate in supportive services. See next section for specific required and optional services shelters must provide.
- Shelters providing shelter to families may not deny shelter to a family on the basis of the age and gender of a child under 18 years of age.
- Shelters must comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. 4821-4946), the Residential Lead-Based Paint Hazard Reduction Act of 1992 (42 U.S.C. 4851-4956), and implementing regulations in 24 CFR part 35, subparts A, B, H, J, K, M, and R.
- Shelters must actively participate in their community's coordinated assessment system.
- Shelters shall not charge money for any housing or supportive service provided.
- Programs must work to link their clients to permanent housing programs, such as rapid rehousing and permanent supportive housing, in the community.

CASE MANAGEMENT SERVICES

STANDARD: Shelters shall provide access to case management services by trained staff to each individual and/or family in the program.

Benchmarks (Standard available services)

- Shelters must provide the client with a written copy of the program rules and the termination process before he/she begins receiving assistance.
- Shelter staff provide regular and consistent case management to shelter residents based on the individual's or family's specific needs. Case management includes:
 - Assessing, planning, coordinating, implementing, and evaluating the services delivered to the resident(s).

- Assisting clients to maintain their shelter bed in a safe manner and understand how to get along with fellow residents.
- Helping clients to create strong support networks and participate in the community as they desire.
- Creating a path for clients to permanent housing through providing rapid rehousing or permanent supportive housing or a connection to another community program that provides these services.
- If the shelters provide case management as part of its programs, use of the Case Management Tool for ongoing case management and measurement of acuity over time, determining changes needed to better serve residents.
- Shelter staff or other programs connected to the shelter through a formal or informal relationship will assist residents in accessing cash and non-cash income through employment, mainstream benefits, childcare assistance, health insurance, and others.
Ongoing assistance with basic needs.

Benchmarks (Optional but recommended services, often from other providers)

- Representative payee services.
- Basic life skills, including housekeeping, grocery shopping, menu planning and food preparation, consumer education, bill paying/budgeting/financial management, transportation, and obtaining vital documents (social security cards, birth certificates, school records).
- Relationship-building and decision-making skills.
- Education services such as GED preparation, post-secondary training, and vocational education.
- Employment services, including career counseling, job preparation, resume-building, dress and maintenance.
- Behavioral health services such as relapse prevention, crisis intervention, medication monitoring and/or dispensing, outpatient therapy and treatment.
- Physical health services such as routine physicals, health assessments, and family planning.
- Legal services related to civil (rent arrears, family law, uncollected benefits) and criminal matters (warrants, minor infractions).

TERMINATION

STANDARD: Termination should be limited to only the most severe cases. Programs will exercise sound judgment and examine all extenuating circumstances when determining if violations warrant program termination (24 CFR 576.402). BoS recommends programs work with other community service providers to develop a board to hear client grievances.

Benchmarks

- In general, if a resident violates program requirements, the shelter may terminate assistance in accordance with a formal process established by the program that recognizes the rights of individuals and families affected. The program is responsible for providing evidence that it considered extenuating circumstances and made significant attempts to help the client continue in the program. Programs should have a formal, established grievance process in its policies and procedures for residents who feel the shelter wrongly terminated assistance.

- Shelters must provide the client with a written copy of the program rules and the termination process before he/she begins receiving assistance and keep a copy signed by the client in the file.
- Programs may carry a barred list when a client has presented a terminal risk to staff or other clients. If a barred client presents him/herself at a later date, programs should review the case to determine if the debarment can be removed to give the program a chance to provide further assistance at a later date.

CLIENT AND PROGRAM FILES

STANDARD: Shelters will keep all client files up-to-date and confidential to ensure effective delivery and tracking of services.

Benchmarks

- Client and program files should, at a minimum, contain all information and forms required by HUD at 24 CFR 576.500 and the state ESG office, service plans, case notes, referral lists, and service activity logs including services provided directly by the shelter program and indirectly by other community service providers. ESG requires:
 - Documentation of homeless status (see above for the priority of types of documentation)
 - Determination of ineligibility, if applicable, which shows the reason for this determination
 - Annual income evaluation
 - Program participant records
 - Documentation of using the community's coordinated assessment system
 - Compliance with shelter and housing standards
 - Services and assistance provided
 - Expenditures and match
 - Conflict of interest/code of conduct policies
 - Homeless participation requirement
 - Faith-based activity requirement, if applicable
 - Other Federal requirements, if applicable
 - Confidentiality procedures
- All client information should be entered into the HMIS in accordance with data quality, timeliness, and additional requirements found in the agency and user participation agreements. At a minimum, programs must record the date the client enters and exits the program, enter HUD required data elements, and update the client's information as changes occur.
- Programs must maintain the security and privacy of written client files and shall not disclose any client-level information without written permission of the client as appropriate, except to program staff and other agencies as required by law. Clients must give informed consent to release any client identifying data to be utilized for research, teaching, and public interpretation. All programs must have a consent for release of information form for clients to use to indicate consent in sharing information with other parties.
- All records pertaining to ESG funds must be retained for the greater of 5 years or the participant records must be retained for 5 years after the expenditure of all funds from the

grant under which the program participant was served. Agencies may substitute original written files with microfilm, photocopies, or similar methods.

EVALUATION AND PLANNING

STANDARD: Shelter will conduct ongoing planning and evaluation to ensure programs continue to meet community needs for individuals and families experiencing homelessness.

Benchmarks

- Agencies maintain written goals and objectives for their services to meet outcomes required by ESG.
- Programs review case files of clients to determine if existing services meet their needs. As appropriate, programs revise goals, objectives, and activities based on their evaluation.
- Programs conduct, at a minimum, an annual evaluation of their goals, objectives, and activities, making adjustments to the program as needed to meet the needs of the community.
- Programs regularly review project performance data in HMIS to ensure reliability of data. Programs should review this information, at a minimum, quarterly.

NC Balance of State Continuum of Care Program Standards

Transitional Housing

Overview

The NC Balance of State Continuum of Care has developed these program standards to provide specific guidelines for how programs can operate to have the best chance of ending homelessness. These guidelines create consistency across the Balance of State, protect our clients by putting their needs first, and provide a baseline for holding all CoC programs to a specific standard of care.

The Department of Housing and Urban Development (HUD) requires every Continuum of Care to evaluate outcome of projects funded under the Emergency Solutions Grants program and the Continuum of Care program and report to HUD (24 CFR 578.7(a)(7)). In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services.

In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and consistently follow written standards for providing CoC assistance. At a minimum, these written standards must include:

- Policies and procedures for evaluating individuals' and families' eligibility and determining the process for prioritizing eligible households in emergency shelter, transitional housing, rapid rehousing, and permanent supportive housing programs (24 CFR 578.7(a)(9)).
- Program standards that meet HUD's requirements for Transitional Housing to define policies and procedures for admission, diversion, referral, and discharge standards as well as safeguards to meet needs for special populations such as victims of domestic violence, dating violence, sexual assault, and stalking.
- Policies and procedures for coordination among emergency shelters, transitional housing programs, essential service providers, homelessness prevention programs, rapid rehousing programs, and permanent supportive housing programs.
- Definitions for participation in the CoC's Homelessness Management Information System (or comparable database for domestic violence or victims' service programs).

The Balance of State Continuum of Care developed the following Transitional Housing program standards to ensure:

- Program accountability to individuals and families experiencing homelessness, specifically populations at greater risk or with the longest histories of homelessness

- Program compliance with the Department of Housing and Urban Development
- Service consistency within programs
- Adequate program staff competence and training, specific to the target population served

EXPECTATIONS

All program grantees using Department of Housing and Urban Development Continuum of Care funding must adhere to these performance standards and will be monitored by the Balance of State Continuum of Care to ensure compliance. The BoS CoC recommends that transitional housing programs funded through other sources also follow these standards. These performance standards attempt to provide a high standard of care that places community and client needs first. Based on proven best practices, this high standard of care is necessary to achieve our goal of ending homelessness in the BoS.

TRANSITIONAL HOUSING

Traditionally, agencies have created transitional housing to provide an interim-housing option (18-24 months) for moderately vulnerable individuals and families prior to permanent housing.¹ Several common types of transitional housing programs exist, including: HUD CoC-funded transitional housing, Emergency Solutions Grant-funded transitional housing, VA Grant Per Diem housing, privately-funded transitional housing programs for survivors of/persons fleeing from domestic violence and individuals with substance abuse and alcohol addictions. Recent research has called into question the effectiveness of transitional housing both programmatically and financially, but many communities throughout the NC Balance of State CoC have transitional housing as a housing option. According to the research, service-rich transitional housing costs far more with far fewer exits to permanent housing than best practice programs such as rapid rehousing and permanent supportive housing, which permanently house individuals and families experiencing homelessness rather than providing a temporary housing option.² Rapid rehousing can accomplish the goals of transitional housing in a much more successful and cost-effective way. In light of this research, HUD has lowered its priority of funding transitional housing through the CoC and ESG programs.

The performance standards in this document attempt to provide guidance and insight as to how agencies can use transitional housing to achieve the best possible outcomes. Current transitional housing programs could target their services to special populations shown to respond effectively to this model. HUD has suggested that transitional housing programs may be appropriate to serve homeless youth, those in recovery, and those fleeing domestic violence situations. Traditional transitional housing programs could also consider retooling to either rapid rehousing or permanent supportive housing programs, depending on geography, population, and local needs data (chronically homeless versus families, etc.).³

Nationally, many transitional housing programs are redirecting their resources toward providing a truly interim housing solution for high-need, high-acuity individuals and families

¹ <https://www.gpo.gov/fdsys/granule/CFR-2012-title24-vol3/CFR-2012-title24-vol3-part576/content-detail.html>



² <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf>

³ [http://www.endhomelessness.org/page/-/files/Retooling Transitional Housing Checklist.pdf](http://www.endhomelessness.org/page/-/files/Retooling%20Transitional%20Housing%20Checklist.pdf)



experiencing homelessness. In the NC Balance of State, emergency shelters continue to turn away high-need individuals and families. This is where transitional housing programs can play an essential role by providing triage or interim beds for individuals and families experiencing chronic homelessness or others with multiple disabling conditions that inhibit them from entering shelter. Transitional housing programs can provide a short-term housing solution for individuals and families who cannot access traditional emergency shelter but need a place to stay until rapid rehousing and permanent supportive housing providers can identify a suitable permanent housing placement, a model known as bridge housing.⁴ With intensive services and no negative effects due to shorter stays, transitional housing, with a few minor changes, could provide a powerful interim housing solution rather than a high-cost “housing readiness” approach.

Every transitional housing program within the NC Balance of State should participate in their Regional Committee’s coordinated assessment system, including the Balance of State prioritization of individuals for housing. In the Balance of State, each community utilizes the Prevention and Diversion screening tool and the Individual and Family VI-SPDAT Prescreen Tools to set priorities and housing triage methods, while housing programs use the Case Management Tool for more developed housing placement purposes and for intensive case management over time. Communities use the VI-SPDAT to prioritize individuals and families experiencing literal homelessness based on an acuity score that indicates the type of housing intervention best suited to their ongoing needs.

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Chronically Homeless: (1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) had been homeless and living as described in (i) continuously for at least 12 months or on at least 4 occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe

⁴ <https://www.hudexchange.info/resources/documents/Deputy-Secretary-of-Veterans-Affairs-Letter-to-GPD>



[Grantees.pdf](#)



haven, or an emergency shelter immediately before entering the care facility; (2) an individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) a family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in (1) or 2) of this definition, including a family whose composition had fluctuated while the head of household has been homeless. (24 CFR 578.3)

Comparable Database: HUD-funded providers of housing and services (recipients of ESG and/or CoC funding) who cannot enter information by law into HMIS (victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database comparable to HMIS. According to HUD, “a comparable database . . . collects client-level data over time and generates unduplicated aggregate reports based on the data.” The recipient or subrecipient of CoC and ESG funds may use a portion of those funds to establish and operate a comparable database that complies with HUD’s HMIS requirements. (24 CFR 578.57)

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Disabling Condition: According to HUD: (1) a condition that: (i) is expected to be of indefinite duration; (ii) substantially impedes the individual’s ability to live independently; (iii) could be improved by providing more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or a developmental disability, as defined above; or the



disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from AIDS, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5)



Diversion: Diversion is a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion practices and programs help reduce the number of people becoming homeless and the demand for shelter beds.

Family: A family includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) a single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or (2) a group of persons residing together, and such group includes, but is not limited to: (i) a family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) an elderly family; (iii) a near-elderly family; (iv) a disabled family; (v) a displaced family; and (vi) the remaining member of a tenant family. (24 CFR 5.403)

Homeless:

Category 1: an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals); or (iii) an individual who exits an institution where he/she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

Category 2: an individual or family who will immediately lose their primary nighttime residence, provided that: (i) the primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) no subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing; or

Category 4: any individual or family who: (i) is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence; (ii) had no other residence; and (iii) lacks the resources or support networks (e.g. family, friends, and faith-based or other social networks) to obtain other permanent housing. (24 CFR 578.3)

Housing First: A national best practice model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment compliance, and service and/or income requirements. Programs offer



supportive services to maximize housing stability to prevent returns to homelessness rather than meeting arbitrary benchmarks prior to permanent housing entry.⁵

Prevention and Diversion Screening Tool: A tool used to reduce entries into the homeless service system by determining a household's needs upon initial presentation to shelter or other emergency response organization. This screening tool gives programs a chance to divert households by assisting them to identify other permanent housing options and, if needed, providing access to mediation and financial assistance to remain in housing.

Rapid Rehousing: A national best practice model designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve long-term stability. Like Housing First, rapid rehousing assistance does not require adherence to preconditions such as employment, income, absence of criminal record, or sobriety. Financial assistance and housing stabilization services match the specific needs of the household. The core components of rapid rehousing are housing identification/relocation, short- and/or medium-term rental and other financial assistance, and case management and housing stabilization services. (24 CFR 576.2)

Transitional Housing: Temporary housing for participants who have signed a lease or occupancy agreement with the purpose of transitioning participants into permanent housing within 24 months.

VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool): An evidence-based tool used by all regions in the Balance of State to determine initial acuity and set prioritization and intervention for permanent housing placement.

PERFORMANCE STANDARDS

PERSONNEL

STANDARD: The program shall adequately staff services with qualified personnel to ensure quality of service delivery, effective program administration, and the safety of program participants.

Benchmarks

- ☐ The organization selects employees and/or volunteers with adequate and appropriate knowledge, experience, and stability for working with individuals and families experiencing homelessness and/or other issues that place individuals and families at risk of homelessness.
- ☐ The organization provides time for all employees and/or volunteers to attend webinars and/or trainings on program requirements, compliance and best practices.
- ☐ The organization trains all employees and/or volunteers on program policies and procedures, available local resources, and specific skills areas relevant to assisting clients in the program.

⁵ <http://www.endhomelessness.org/page/-/files/4.2%20Housing-Focused%20Emergency%20Shelter%20>



[%20Ralph%20Payton.pdf](#)



- ☐ For programs using the Homeless Management Information System (HMIS), all end users must abide by the NC HMIS User and Participation Agreements, including adherence to the strict privacy and confidentiality policies.
- ☐ Staff supervisors of casework, counseling, and/or case management services have, at a minimum, a bachelor's degree in a human service-related field and/or experience working with individuals and families experiencing homelessness and/or other issues that place individuals and families at risk of homelessness.
- Staff supervising overall program operations have, at a minimum, a bachelor's degree in a human service-related field and/or demonstrated ability and experience that qualifies them to assume such responsibility.
- ☐ All program staff have job descriptions that address tasks staff must perform and the minimum qualifications for the position.
- ☐ Case managers provide case management with the designated Case Management Tool on a frequent basis (every six months minimum) for all clients.
- ☐ Organizations should share and train all program staff on the NC Balance of State Transitional Housing Written Standards.

PRIORITY FOR TENANTS WHO NEED EMERGENCY TRANSFERS UNDER VAWA 2013

STANDARD: Tenants eligible for emergency transfers under the NC BoS CoC's emergency transfer policy and VAWA statute and regulations have first priority for open transitional housing units, if they also meet all eligibility requirements and prioritization requirements for the project.

CLIENT INTAKE PROCESS

STANDARD: Programs will actively participate in their community's coordinated assessment system. The program will limit entry requirements to ensure that the program serves the most vulnerable individuals and families needing assistance.

Benchmarks

- ☐ All adult program participants must meet the following program eligibility requirements:
 - 18 years or older
 - Literally homeless, imminently at risk of homelessness, and/or fleeing or attempting to flee domestic violence (see definitions listed above for Category 1, 2, and 4 of the homelessness definition)
- ☐ Programs may not require clients to meet additional program eligibility requirements except for the following:
 - Chronically homeless
 - Residency requirements (abiding by the language of the occupancy agreement)
- ☐ All CoC and ESG recipients must use the standard order of priority for documenting evidence to determine homeless status and chronically homeless status. Grantees must document in the client file that the agency attempted to obtain documentation in the preferred order. The order should be as follows:
 - Third-party documentation (including HMIS)
 - Intake worker observations through outreach and visual assessment
 - Self-certification of the person receiving assistance



- ☐ Programs can only turn away individuals and families experiencing homelessness from program entry for the following reasons:



- Household make-up (provided it does not violate HUD's Fair Housing and Equal Opportunity requirements): singles-only programs can disqualify households with children; families-only programs can disqualify single individuals
- All program beds are full
- If the program has in residence at least one family with a child under the age of 18, the program may exclude registered sex offenders and persons with a criminal record that includes a violent crime from the program so long as the child resides in the same housing facility (24 CFR 578.93)
- ☐ Programs cannot disqualify an individual or family from entry because of employment status or lack of income.
- ☐ Programs cannot disqualify an individual or family because of evictions or poor rental history.
- ☐ Programs may make services available and encourage adult household members to participate in program services, but cannot make service usage a requirement to deny initial or ongoing assistance.
- ☐ Programs will maintain release of information, case notes, and all pertinent demographic and identifying data in HMIS as allowable by program type. Paper files should be maintained in a locked cabinet behind a locked door with access strictly reserved for case workers and administrators who need said information.

TRANSITIONAL HOUSING

STANDARD: The program will provide safe, affordable housing that meets clients' needs in accordance with the client intake process and guidelines set by the Department of Housing and Urban Development.

Benchmarks

- ☐ When providing or arranging for housing, the program must consider the needs of the individual or family experiencing homelessness.
- ☐ The program provides assistance in accessing suitable permanent housing.
- ☐ The program may provide assistance with moving costs (24 CFR 578.53(e)(2)).
- ☐ The program has participants sign occupancy agreements or subleases, regardless of whether the agency owns the housing units or not (24 CFR 578.77(a)).
- ☐ The program enters into an agreement with clients for at least one month and up to 24 months (24 CFR 578.79). The program should work with the client to minimize his/her time in temporary housing and consistently and regularly evaluate and engage him/her for permanent housing placement.
- ☐ In accordance with 24 CFR 578.77, programs do not have to charge clients occupancy fees. However, if the program does charge occupancy fees, the program must impose them on every household served by the program. If the program charges occupancy fees, they may not exceed the highest of:
 - 30% of the household's monthly adjusted gross income;
 - 10% of the household's monthly income; or
 - If the household receives payments for welfare assistance from a public agency wherein part of the payment is for housing costs, the portion of the payment designated for housing costs.



Programs must outline the occupancy payment policy as part of its program manual.



- ☐ Programs providing housing to families may not deny housing to a family on the basis of age and gender of a child under the age of 18 years of age.
- Programs must actively participate in their Regional Committee’s coordinated assessment process.
- ☐ Programs must review and ensure that their program policies do not create undue barriers to program entry and program participation.

CASE MANAGEMENT SERVICES

STANDARD: The program shall provide access to case management services by trained staff to each individual and/or family in the program.

Benchmarks (Standard available services)

- ☐ Transitional housing programs provide regular and consistent case management to clients based on the individual’s or family’s specific needs. Case management includes:
 - Assessing, planning, coordinating, implementing, and evaluating the services delivered to the client(s).
 - Assisting clients to maintain their transitional housing placement in a safe manner and understand how to get along with fellow residents.
 - Helping clients to create strong support networks and participate in the community, as they desire.
 - Creating a path for clients to permanent housing as quickly as possible through providing rapid rehousing or permanent supportive housing or a connection to another community program that provides these services.
 - Using the Case Management Tool for ongoing case management and measurement of acuity over time, determining changes needed to better serve residents.
- ☐ Programs provide individualized budgeting and money management services to clients as needed.
- ☐ Program staff or other programs connected to the transitional housing program through a formal or informal relationship will assist clients in accessing cash and non-cash income through employment, mainstream benefits, childcare assistance, health insurance, and other sources.

Benchmarks (Optional but recommended services, often from other providers)

- ☐ Representative payee services.
- ☐ Basic life skills, including housekeeping, grocery shopping, menu planning and food preparation, consumer education, transportation, obtaining vital documents (social security cards, birth certificates, school records).
- ☐ Relationship-building and decision-making skills.
- ☐ Education services such as GED preparation, post-secondary training, and vocational education.
- ☐ Employment services, including career counseling, job preparation, job search, resume-building, dress and maintenance.
- ☐ Behavioral health services such as relapse prevention, crisis intervention, medication monitoring and/or dispensing, outpatient therapy and treatment.
- ☐ Physical health services such as routine physicals, health assessments, and family planning.



- ☐ Legal services related to civil (rent arrears, family law, uncollected benefits) and criminal matters (warrants, minor infractions).
- ☐ Ongoing assistance with food, clothing, and transportation.

TERMINATION

STANDARD: Termination should be limited to only the most severe cases. Programs will exercise sound judgment and examine all extenuating circumstances when determining if violations warrant program termination (24 CFR 578.91). BoS recommends programs work with other community service providers to develop a board to hear client grievances.

Benchmarks

- ☐ The program may terminate services when clients violate the terms of their occupancy agreement.
- ☐ If the program terminates services for reasons other than the above, it is responsible for providing evidence that it considered extenuating circumstances and made significant attempts to help the client continue in the program. This includes a formal process, recognizing the rights of the individuals receiving assistance under the due process of law. This process, at a minimum, must consist of:
 - Providing the client(s) with a written copy of the program rules and the termination process before the client(s) begins receiving assistance and keeping a copy signed by the client in the file.
 - Written notice to the client containing a clear statement of the reasons for termination.
 - Review of the decision, in which the client(s) can present written or oral objections before a person other than the person who approved the termination decision.
 - Prompt written notice of the final decision to the client.
- ☐ Programs follow a termination process and have a process for appeals/grievances in accordance with 24 CFR 578.91 in regard to due process. Programs provide this information to clients at the beginning of the program and if/when the termination of services occurs with a signed copy kept in the client file.
- Termination does not bar the program from providing further assistance at a later date to the same individual or family. Programs should never carry a “barred list” of clients unless said client has presented a terminal risk to staff or other clients.
- ☐ Programs should not terminate clients from services because of entry into an institution (medical, mental health, substance abuse, jail). Providers can maintain open units for individuals and families who are institutionalized for a maximum of 90 days.

FOLLOW-UP SERVICES

STANDARD: Programs must ensure a continuity of services to all clients exiting their programs. Agencies can provide these services directly or through referrals to other agencies.

Benchmarks

- Using the Case Management Tool, programs work with clients to develop exit plans for clients whose forward progress demonstrates potential success (acuity score threshold to be determined by the community’s coordinated assessment system) in market rate or



subsidized housing. Programs should work with clients to exit when they meet this



threshold score even if they have not reached the maximum number of months in the program.

- ☐ Programs prioritize the development of exit plans for each client to ensure continued permanent housing stability and connection to community resources, as desired.
- ☐ Programs should attempt to follow up with clients through verbal or written contact at least once after the client exits services. A program may provide follow-up services to include identification of additional needs and referral to other agency and community services.

CLIENT AND PROGRAM FILES

STANDARD: Transitional housing programs will keep all client files up-to-date and confidential to ensure effective delivery and tracking of services

Benchmarks

- ☐ Client files should, at a minimum, contain all information and forms required by HUD (24 CFR 578.103 for CoC and 24 CFR 576.599 for ESG) and the state ESG office, service plans, case notes, referral lists, and service activity logs, including services provided directly by the transitional housing program and indirectly by other community service providers. Programs should have:
 - Documentation of homeless status (see above for the priority of types of documentation).
 - Determination of ineligibility, if applicable, which shows the reason for this determination.
 - Annual income evaluation.
 - Program participant records.
 - Documentation of using the community's coordinated assessment system.
 - Compliance with shelter and housing standards.
 - Services and assistance provided.
 - Expenditures and match.
 - Conflict of interest/code of conduct policies.
 - Homeless participant requirement.
 - Faith-based activity requirements, if applicable.
 - Other Federal requirements, if applicable.
 - Confidentiality procedures.
- All client information should be entered in the NC HMIS in accordance with data quality, timeliness, and additional requirements found in the agency and user participation agreements. At a minimum, programs must record the date the client enters and exits the program, HUD required data elements, and an update of clients' information as changes occur.
- ☐ Program must maintain a release of information form for clients to use to indicate consent in sharing information with other parties. This cannot be a general release but one that indicates sharing information with specific parties for specific reasons.
- ☐ Programs must maintain the security and privacy of written client files and shall not disclose any client-level information without written permission of the client as appropriate, except



to program staff and other agencies as required by law. Clients must give informed consent



to release any client identifying data to be utilized for research, teaching, and public interpretation.

- ☐ All records pertaining to HUD CoC or ESG funds must be retained for the greater of 5 years or the participant records must be retained for 5 years after the expenditure of all funds from the grant under which the program participant was served. Agencies may substitute original written files with microfilm, photocopies, or similar methods. Records pertaining to other funding sources must adhere to those record retention requirements.

EVALUATION AND PLANNING

STANDARD: Transitional housing programs will work with the community to conduct ongoing planning and evaluation to ensure programs continue to meet community needs for individuals and families experiencing homelessness.

Benchmarks

- ☐ Agencies maintain written goals and objectives for their services to meet outcomes required by the HUD CoC and ESG programs or other funding sources.
- ☐ Programs review case files of clients to determine if existing services meet their needs. As appropriate, programs revise goals, objectives, and activities based on their evaluation.
- ☐ Programs conduct, at a minimum, an annual evaluation of their goals, objectives, and activities, making adjustments to the program as needed to meet the needs of the community.
- ☐ Programs regularly review project performance data in HMIS to ensure reliability of data. Programs should review this information, at a minimum, quarterly.
- ☐ Programs that regularly operate below 100% utilization of their beds must review their eligibility criteria and program rules to ensure they are not screening out households who need program beds to transition into permanent housing.
- ☐ Program must follow other Federal requirements for CoC programs at 24 CFR 578.99 and for ESG programs at 24 CFR 576.407, as applicable.



NC Balance of State Continuum of Care Program Standards Homelessness Prevention and Rapid Rehousing

OVERVIEW

The NC Balance of State Continuum of Care has developed these program standards to provide specific guidelines for how programs can operate to have the best chance of ending homelessness. These guidelines create consistency across the Balance of State, protect our clients by putting their needs first, and provide a baseline for holding all CoC programs to a specific standard of care. The BoS CoC has used the Rapid Rehousing Performance Benchmarks and Program Standards document published by the National Alliance to End Homeless in partnership with the U.S Department of Veteran Affairs, the U.S Department of Housing and Urban Development, the U.S. Interagency Council on Homelessness, Abt Associates, other federal technical assistance providers, and nationally recognized high-performing rapid rehousing providers. This document provides details on performance benchmarks that would qualify programs as effective at ending and preventing homelessness.¹

The Department of Housing and Urban Development (HUD) requires every Continuum of Care to evaluate outcomes of projects funded under Emergency Solutions Grants program and the Continuum of Care program and report to HUD (24 CFR 578.7(a)(7). In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and operate either a centralized or coordinated assessment system that provides an initial comprehensive assessment of the needs of individuals and families for housing and services.

In consultation with recipients of ESG and CoC program funds within the geographic area, establish and consistently follow written standards for providing CoC assistance. At a minimum, these written standards must include:

- Policies and procedures for evaluating individuals' and families' eligibility and determining the process for prioritizing eligible households in emergency shelter,



transitional housing, rapid rehousing, and permanent supportive housing programs (24 CFR 578.7(a)(9)).

- For homelessness prevention and rapid rehousing programs, program standards to define policies and procedures for prioritization of eligible households, to set the percentage or amount of financial assistance and housing stabilization services to households, and to determine the length of time the assistance will last.

¹<http://www.endhomelessness.org/library/entry/rapid-re-housing-performance-benchmarks-and-program-standards>



- Policies and procedures for coordination among emergency shelters, transitional housing programs, essential service providers, homelessness prevention programs, rapid rehousing programs, and permanent supportive housing programs.
- Definitions for participation in the CoC's Homeless Management Information System (or comparable database for domestic violence or victims' service programs).

The Balance of State Continuum of Care developed the following homelessness prevention and rapid rehousing program standards to ensure:

- Program accountability to individuals and families experiencing homelessness, specifically populations at greater risk or with the longest histories of homelessness
- Program compliance with the Department of Housing and Urban Development and the Department of Veteran Affairs
- Service consistency within programs
- Adequate program staff competence and training specific to the target population served

EXPECTATIONS

All program grantees using Department of Housing and Urban Development Continuum of Care, Emergency Solutions Grant, VA SSVF, and HOME TBRA funding must adhere to these performance standards. Programs funded through the Continuum of Care and Emergency Solutions Grant will be monitored by the Balance of State Continuum of Care to ensure compliance. The BoS CoC recommends that homelessness prevention and rapid rehousing programs funded through other sources also follow these standards. These performance standards attempt to provide a high standard of care that places community and client needs first. Based on proven best practices, this high standard of care is necessary to achieve our goal of ending homelessness in the BoS.

Some requirements and parameters for homelessness prevention and rapid rehousing assistance vary from program to program. It will be necessary to refer to the regulation for each program along with these program standards (CoC: 24 CFR 587; ESG: 24 CFR 576; SSVF: 38 CFR 62; HOME: 24 CFR 570). The program standards note many of the differences below in each of the following sections. For other helpful documents to check for compliance with requirements, see the footnotes below.²

HOMELESSNESS PREVENTION AND RAPID REHOUSING

Rapid rehousing provides an immediate permanent housing solution for vulnerable homeless individuals and families by providing short-term rental assistance and services.³ Common publicly-funded types of rapid rehousing programs include HUD CoC-funded rapid rehousing, Emergency Solutions Grant-funded rapid rehousing, Supportive Services for Veteran Families (SSVF) programs funded through the Department of Veteran Affairs, and Tenant-Based Rental Assistance programs funded through the HOME Investments Partnership (HOME) formula grant

² https://www.hudexchange.info/resources/documents/Rapid_Re-Housing_ESG_vs_CoC.pdf;
http://portal.hud.gov/hudportal/HUD?src=/program_offices/administration/hudclips/handbooks/cpd/6509.2

³ <https://www.gpo.gov/fdsys/granule/CFR-2012-title24-vol3/CFR-2012-title24-vol3-part576/content-detail.html>



program. Research shows rapid rehousing to be one of the most effective types of contemporary homeless service programs to end homelessness from a financial and housing stability perspective.⁴

In general, rapid rehousing programs have latitude in determining the target population the program will serve and a great degree of flexibility in how programs apply subsidies, in duration and amount, to house and stabilize individuals and families experiencing homelessness. Many rapid rehousing programs focus on ending homelessness among youth and family populations. Others programs focus exclusively on veterans and veteran families. Still others design their programs to target the needs of survivors of domestic violence or persons experiencing chronic or episodic homelessness. Rapid rehousing is an intervention that can adapt to serve individuals, families and youth with a variety of housing barriers.

Homelessness prevention programs can play an important role in ending homelessness. Like rapid rehousing programs, homelessness prevention programs can focus financial assistance and housing stabilization services on specific populations, including survivors of domestic violence, families with children, and formerly homeless individuals and families. While research clearly shows the effectiveness of rapid rehousing programs on reducing homelessness in communities, homelessness prevention programs demonstrate mixed results. In order to end homelessness, communities understand they must prevent new episodes of homelessness and returns to homelessness for individuals and families in housing crises. However, it can be difficult to determine which households would have become homeless if not for this intervention. Data suggests that only one out of ten households presenting to prevention programs would actually become homeless without financial assistance. In light of this research, homelessness prevention programs should target their limited financial assistance and housing stability resources appropriately and develop methods to determine which households are at greatest risk of becoming homeless. In order to do so, prevention programs are encouraged to focus their spending on households who are at imminent risk of homelessness (within 72 hours) or those households who can be diverted from the shelter system with the aid of financial assistance. Homelessness prevention programs should target their funding towards households that have similar characteristics to the general homeless population in their community.

No matter the focus population, all BoS CoC homelessness prevention and rapid rehousing programs should adopt a Housing First philosophy by reducing barriers to eligibility (i.e. no income, sobriety, and rental history) and housing people as quickly as possible. These programs should also participate in their Regional Committee's coordinated assessment process, including the local prioritization of individuals for housing. In the BoS CoC, each community utilizes the Prevention and Diversion screening tool and the Individual and Family VI-SPDAT Prescreen Tools to set priorities and housing triage methods, while permanent housing programs use the Case Management Tool for more developed housing placement purposes and for intensive case management over time. Communities use the VI-SPDAT to prioritize

⁴ <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000265-Rapid-Re-housing-What-the-Research-Says.pdf>



individuals and families experiencing literal homelessness based on an acuity score that indicates the type of housing intervention best suited to their ongoing needs.

DEFINITIONS

Acuity: When using the VI-SPDAT prescreens, acuity means the presence of a presenting issue based on the prescreening score. Acuity on the prescreening tool is expressed as a number with the higher score representing more complex, co-occurring issues likely to impact overall stability in permanent housing. When using the Case Management Tool acuity refers to the severity of the presenting issue and the ongoing goals to addressing these issues.

Case Management Tool: A standardized tool for case management to track outcomes in the coordinated assessment process. Housing programs administer this tool at program entry, housing entry, and every six months thereafter until program discharge. Upon discharge from the program, housing case managers administer the tool one final time 12 months later, when possible, to ensure the household continues to make progress.

Chronically Homeless: (1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) had been homeless and living as described in (i) continuously for at least 12 months or on at least 4 occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the care facility; (2) an individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) a family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in (1) or 2) of this definition, including a family whose composition had fluctuated while the head of household has been homeless. (24 CFR 578.3)

Comparable Database: HUD-funded providers of housing and services (recipients of ESG and/or CoC funding) who cannot enter information by law into HMIS (victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database comparable to HMIS. According to HUD, “a comparable database . . . collects client-level data over time and generates unduplicated aggregate reports based on the data.” The recipient or subrecipient of CoC and ESG funds may use a portion of those funds to establish and operate a comparable database that complies with HUD’s HMIS requirements. (24 CFR 578.57)

Coordinated Assessment: “A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The . . . system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and



includes a comprehensive and standardized assessment tool” (24 CFR 578.3). CoC’s have ultimate responsibility to implement coordinated assessment in their geographic area.

Developmental Disability: As defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002): (1) A severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major life activities: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; (v) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (2) an individual from birth to age 9, inclusive, who has a substantial developmental disability or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria in (1)(i) through (v) of the definition of “developmental disability” in this definition if the individual, without services or supports, has a high probability of meeting these criteria later in life. (24 CFR 578.3)

Disabling Condition: According to HUD: (1) a condition that: (i) is expected to be of indefinite duration; (ii) substantially impedes the individual’s ability to live independently; (iii) could be improved by providing more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or a developmental disability, as defined above; or the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from AIDS, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5)

Diversion: Diversion is a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion practices and programs help reduce the number of people becoming homeless and the demand for shelter beds.

Family: A family includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) a single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or (2) a group of persons residing together, and such group includes, but is not limited to: (i) a family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) an elderly family; (iii) a near-elderly family; (iv) a disabled family; (v) a displaced family; and (vi) the remaining member of a tenant family. (24 CFR 5.403)

Homeless:

Category 1: an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping



accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals); or (iii) an individual who exits an institution where he/she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

Category 2: an individual or family who will immediately lose their primary nighttime residence, provided that: (i) the primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) no subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing; or

Category 4: any individual or family who: (i) is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence; (ii) had no other residence; and (iii) lacks the resources or support networks (e.g. family, friends, and faith-based or other social networks) to obtain other permanent housing. (24 CFR 578.3)

Housing First: A national best practice model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment compliance, and service and/or income requirements. Programs offer supportive services to maximize housing stability to prevent returns to homelessness rather than meeting arbitrary benchmarks prior to permanent housing entry.⁵

Prevention and Diversion Screening Tool: A tool used to reduce entries into the homeless service system by determining a household's needs upon initial presentation to shelter or other emergency response organization. This screening tool gives programs a chance to divert households by assisting them to identify other permanent housing options and, if needed, providing access to mediation and financial assistance to remain in housing.

Rapid Rehousing: A national best practice model designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve long-term stability. Like Housing First, rapid rehousing assistance does not require adherence to preconditions such as employment, income, absence of criminal record, or sobriety. Financial assistance and housing stabilization services match the specific needs of the household. The core components of rapid rehousing are housing identification/relocation, short- and/or medium-term rental and other financial assistance, and case management and housing stabilization services. (24 CFR 576.2)

⁵ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf>



Transitional Housing: Temporary housing for participants who have signed a lease or occupancy agreement with the purpose of transitioning participants into permanent housing within 24 months.

VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool): An evidence-based tool used by all regions in the Balance of State to determine initial acuity and set prioritization and intervention for permanent housing placement.

PERFORMANCE STANDARDS PERSONNEL STANDARD:

Programs shall adequately staff services with qualified personnel to ensure quality of service delivery, effective program administration, and the safety of program participants.

Benchmarks

- The organization selects employees and/or volunteers with adequate and appropriate knowledge, experience, and stability for working with individuals and families experiencing homelessness and/or other issues that place individuals and families at risk of homelessness.
- The organization provides time for all employees and/or volunteers to attend webinars and/or trainings on program requirements, compliance and best practices.
- The organization trains all employees and/or volunteers on program policies and procedures, available local resources, and specific skill areas relevant to assisting clients in the program.
- Program designates staff whose responsibilities include identification and recruitment of landlords, encouraging them to rent to homeless households served by the program. Staff have the knowledge, skills, and agency resources to: understand landlords' perspectives, understand landlord and tenant rights and responsibilities, and negotiate landlord supports. Grantees should train their case management staff who have housing identification responsibilities on this specialized skill set to perform the landlord recruitment function effectively.
- For programs using the Homeless Management Information System (HMIS), all end users must abide by the NC HMIS End User and Participation Agreements, including adherence to the strict privacy and confidentiality policies.
- Staff supervisors of casework, counseling, and/or case management services have, at a minimum, a bachelor's degree in a human service-related field and/or experience working with individuals and families experiencing homelessness and/or other issues that place individuals and families at risk of homelessness.
- Staff supervising overall program operations have, at a minimum, a bachelor's degree in a human service-related field and/or demonstrated ability and experience that qualifies them to assume such responsibility.
- All program staff have written job descriptions that address tasks staff must perform and the minimum qualifications for the position. Ideally, homelessness prevention and rapid rehousing programs would have dedicated staff for housing identification and landlord recruitment. However, if programs do not have the capacity to have dedicated staff, case manager job descriptions must include responsibilities for landlord recruitment and negotiation.



- Case managers provide case management with the designated Case Management Tool on a frequent basis (minimum of monthly) for all clients.
- Organizations should share and train all program staff on the NC Balance of State Homelessness Prevention and Rapid Rehousing Written Standards.

PRIORITY FOR TENANTS WHO NEED EMERGENCY TRANSFERS UNDER VAWA 2013

STANDARD: Tenants eligible for emergency transfers under the NC BoS CoC's emergency transfer policy and VAWA statute and regulations have first priority for open rapid re-housing units, if they also meet all eligibility requirements and prioritization requirements for the project.

CLIENT INTAKE PROCESS

STANDARD: Programs will actively participate in their community's coordinated assessment system by only taking referrals from the coordinated assessment system for their program. At a minimum, programs will perform the Prevention and Diversion screening tool to determine the ability of the program to divert the presenting household from the homeless service system and/or the VI-SPDAT Prescreen on all program applicants to determine their acuity score. The program will limit entry requirements to ensure that the program serves the most vulnerable individuals and families needing assistance.

Benchmarks

- All adult program participants must meet the following program eligibility requirements:
 - Rapid rehousing programs work with households who meet the definition of homelessness in the definitions section of the performance standards (CoC RRH programs may work with participants in Categories 1 and 4. ESG RRH programs may work with participants in Category 1 and literally homeless participants in Category 4). SSVF programs should follow specific guidelines for eligible participants.
 - Homelessness prevention programs work with households who meet the at-risk of homelessness definition (Category 2) in the definitions section of the performance standards.
 - Adult household members have the ability to participate in developing and carrying out an appropriate housing stability plan and maintain accountability of said plan.
 - CoC programs should also assess participant eligibility based on eligibility criteria established by the NOFA for the year of the award.
- Programs cannot disqualify an individual or family because of prior evictions, poor rental history, criminal history, or credit history.
- Programs explain the available services, encouraging each adult household member to participate in said services, but does not make service usage a requirement or the refusal of services a reason for disqualification or eviction unless service requirements are attached to funding (SSVF grants have a service requirement).
- Programs must use the standard order of priority of documenting evidence to determine homeless status and chronically homeless status per the program's eligibility requirements. Grantees must document in the client file that the agency attempted to obtain the documentation in the preferred order. The order should be as follows:
 - Third-party documentation (including HMIS)
 - Intake worker observations through outreach and visual assessment



- Self-certification of the person receiving assistance
- Programs will maintain release of information, case notes, and all pertinent demographic and identifying data in HMIS as allowable by program type. Paper files should be maintained in a locked cabinet behind a locked door with access reserved for case workers and administrators who need said information.
- Programs can turn away individuals and families experiencing homelessness from program entry for only the following reasons:
 - Household makeup (provided it does not violate HUD's Fair Housing and Equal Opportunity requirements): singles-only programs can disqualify households with children; families-only programs can disqualify single individuals
 - Prevention and rapid rehousing subsidy money has been exhausted
 - If the housing has in residence at least one family member with a child under the age of 18, the program may exclude registered sex offenders and persons with a criminal record that includes a violent crime from the program so long as the child resides in the same housing facility (24 CFR 578.93)
 - For SSVF and HOME programs only, the family or individual has household income over 50% of area median income

HOMELESSNESS PREVENTION

STANDARD: Programs will assist participants in staying in their current housing situation, if possible, or assist households at imminent risk of homelessness to move into another suitable unit as defined under the specific program type.

Benchmarks

- Programs are encouraged to target prevention funds toward community diversion efforts. When paying financial assistance to divert households from homelessness, programs should target assistance to the households most likely to experience homelessness if not for this assistance.
- Programs explain program rules and expectations prior to admitting the individual or family into the program. Programs will have rules and expectations that ensure fairness and avoid arbitrary decisions that can vary from client to client or staff to staff.
- In evaluating current housing, programs consider the needs of the individual or family living there to decide if the current unit meets Housing Quality Standards and long-term sustainability (ESG and SSVF only).
- When moving the individual or family into a new unit, programs consider the needs of the household in terms of location, cost, number of bedrooms, handicap access, etc. Programs will assess potential housing for compliance with program standards for habitability, lead-based paint, and rent reasonableness prior to the individual or family signing a lease and the program signing a rental assistance agreement with the landlord.
- Programs may provide assistance with rental application fees (ESG and SSVF only), moving costs (ESG, CoC, and SSVF only), temporary storage fees (ESG and SSVF programs only), security deposits (up to 2 months for ESG, CoC and HOME), last month's rent (ESG, CoC and SSVF only), utility deposits, utility payments, rental arrears (up to 6 months for ESG), utility arrears (up to 6 months for ESG), credit repair (ESG and CoC only), and legal services (ESG and CoC only) related to obtaining permanent housing. Grantees should



follow the specifics of the grant program under which their program is funded to understand specific restrictions for each program and the maximum number of months allowed for rental and utility assistance.

- Lease: The program participant will sign a lease directly with a landlord or property owner. Grantees may only make payments directly to the landlord or property owner.
- Rental Assistance Agreement: Grantees may make rental and utility assistance payments only to an owner with whom the household has entered into a rental assistance agreement. The rental assistance agreement must set forth the terms under which rental assistance will be provided. The rental assistance agreement must provide that, during the term of the agreement, the landlord must give the grantee a copy of any notice to the program participant to vacate the housing unit or any complaint used under state or local law to commence a legal eviction against a program participant.
- Programs will determine the amount that households will contribute toward their monthly rent payment. The household's payment cannot exceed ESG, CoC, SSVF, or HOME regulations. Except for the HOME TBRA program, programs can choose not to charge households rent during their participation in the program. All rent payments made by program participants must be paid directly to the landlord or property owner. Programs will review the amount of rental assistance paid for the participating household every 3 months, and changes made to the agreement will be determined by continued need and ability of the household to sustain housing long-term.
- Programs may provide no more than 3 months of rental and utility assistance to a participating household for homelessness prevention. If the household needs more than 3 months of financial assistance, the agency Executive Director or his/her designated proxy may extend financial assistance month-to-month based on proof of continued need and demonstrated efficacy of stated housing sustainability plan.
- Use with other subsidies: Except for one-time payment of rental arrears on the program participant's portion of the rental payment, rental assistance cannot be provided to a program participant who receives other tenant-based rental assistance or who is living in a housing unit receiving project-based rental or operating assistance through public sources. Programs can pay for security and utility payments for program participants to move into these units when other funding sources cannot be identified.

RAPID REHOUSING

STANDARD: Programs will assist participants in locating and moving into safe, affordable housing, providing housing stabilization and case management services meant to provide long-term sustainability as defined under the specific program type.

Benchmarks

- Programs explain program rules and expectations prior to admitting the individual or family into the program. Programs have rules and expectations that ensure fairness and avoid arbitrary decisions that vary from client to client or staff to staff.
- Programs consider the needs of the household in terms of location, cost, number of bedrooms, handicap access, and other pertinent information when moving a household into housing. Programs will assess potential housing for compliance with program standards for habitability, lead-based paint, and rent reasonableness prior to the individual



or family signing a lease and the program signing a rental assistance agreement with the landlord.

- Programs may provide assistance with rental application fees (ESG, CoC and SSVF only), moving costs (ESG, SSVF, and CoC only), temporary storage fees (ESG and SSVF programs only), security deposits (up to 2 months for ESG, CoC and HOME), last month's rent (ESG, CoC and SSVF only), utility deposits, utility payments, rental arrears (up to 6 months for ESG), utility arrears (up to 6 months for ESG), credit repair (ESG and CoC only), and legal services (ESG and CoC only) related to obtaining permanent housing. Grantees should follow the specifics of the grant program under which their program is funded to understand specific restrictions for each program and the maximum number of months allowed for rental and utility assistance.
- Lease: The program participant will sign a lease directly with a landlord or property owner. Grantees may only make payments directly to the landlord or property owner. Initial lease agreements should be for one year, renewable for a minimum term of one month and terminable only for cause. HOME TBRA leases should not have prohibited lease provisions (24 CFR 92.253).
- Rental Assistance Agreement: Grantees may make rental and utility assistance payments only to an owner with whom the household has entered into a rental assistance agreement. The rental assistance agreement must set forth the terms under which rental assistance will be provided. The rental assistance agreement must provide that, during the term of the agreement, the landlord must give the grantee a copy of any notice to the program participant to vacate the housing unit or any complaint used under state or local law to commence a legal eviction against a program participant.
- Programs should take a progressive approach when determining the amount that households will contribute toward their monthly rent payment. Programs should remain flexible, taking into account the unique and changing needs of the household. The household's payment cannot exceed ESG, CoC, SSVF, or HOME regulations. Except for the HOME TBRA program, programs can choose not to charge households rent during their participation in the program. All rent payments made by program participants must be paid directly to the landlord or property owner. Programs will review the amount of rental assistance paid for the participating household every 3 months and changes made to the agreement will be determined by continued need and ability of the household to sustain housing long-term. Programs should have written policies and procedures for determining the amount of rent participants pay towards housing costs. This amount must be reasonable based on household income (this could potentially be 50-60% of their monthly income), including \$0 for households with no income. These policies should also address when and how programs use financial assistance as a bridge to housing subsidy or a permanent supportive housing program.
- When determining the amount and length of financial assistance, programs should base their decision on the needs of the household and its long-term housing stability plan. Programs should have well-defined policies and procedures for determining the amount and length of time for financial assistance to program participants as well as defined and objective standards for when case management and/or financial assistance should continue or end. Programs must review the amount of rental assistance provided every 3 months and continued need determined through consultation between the participant and the case



manager. Programs should review regulations for the funding source to determine maximum months they can pay for rental assistance.

- Use with other subsidies: Except for one-time payment of rental arrears on the program participant's portion of the rental payment, rental assistance cannot be provided to a program participant who receives other tenant-based rental assistance or who is living in a housing unit receiving project-based rental or operating assistance through public sources. Programs can pay for security and utility payments for program participants to move into these units when other funding sources cannot be identified.
- HUD CoC grantees will adhere to the responsibilities of grant management outlined by the BoS CoC.⁶

HOUSING STABILIZATION/CASE MANAGEMENT SERVICES

STANDARD: Programs shall provide access to housing stabilization and/or case management services by trained staff to each individual and/or family in the program.

Benchmarks

- Programs provide individual housing stabilization and/or case management services to program participants at least monthly. These services include:
 - Housing stability services to assist participants in locating and obtaining suitable, affordable permanent housing, including:
 - Assessment of housing barriers, needs, and preferences.
 - Development of an action plan for locating housing.
 - Housing search.
 - Outreach to and negotiation with landlords or property owners.
 - Tenant counseling.
 - Assessment of housing for compliance with program type requirements for habitability, lead-based paint and rent reasonableness.
 - Assistance with submitting rental applications.
 - Understanding lease agreements.
 - Arranging for utilities.
 - Making moving arrangements.
 - Assuring participants have the basics at move-in, including simple furnishings, mattresses, and cooking utensils like pots and pans.
 - Case management services, including assessing, arranging, coordinating, and monitoring the delivery of individualized services to facilitate housing stability for participants who have obtained and maintained permanent housing through the homelessness prevention or rapid rehousing program by:
 - Developing, in conjunction with the participant, an individualized housing and service plan with a path to permanent housing stability.
 - Developing, securing, and coordinating services.
 - Obtaining federal, state, and local benefits.
 - Monitoring and evaluating program participants' progress towards goals.
 - Providing information about and referrals to other providers.

⁶ See the signature form with responsibilities: <http://www.ncceh.org/files/6274/>



- Conducting 3-month evaluations to determine ongoing program eligibility.
- Programs may offer other services, including:
 - Legal services to resolve a legal problem prohibiting a program participant from obtaining or retaining permanent housing (only ESG and CoC), including:
 - Client intake.
 - Preparation of cases for trial.
 - Provision of legal advice.
 - Representation of legal advice.
 - Counseling.
 - Filing fees and other necessary court costs.
 - Mediation between the program participant and the owner or person(s) with whom the participant is living (only ESG and CoC).
 - Credit repair (only ESG and CoC), including:
 - Credit counseling.
 - Accessing a free personal credit report.
 - Resolving personal credit problems.
 - Other services needed to assist with critical skills related to household budgeting and money management.
- Case management includes the following types of contact: home visits, office visits, meeting in a location in the community, or phone calls (at least one visit per month must be in person). Programs should use the Case Management Tool as a guide for their case management services to program participants. Meeting times, place and frequency should be mutually agreed upon by both the participant and case manager.
- CoC and ESG RRH programs must meet with participants at least once per month to assist the participant in long-term housing stability. Program staff must conduct an annual assessment of service needs.
- The program will evaluate the household for continued eligibility every three months or as changes are reported in household income and housing stability. To continue receiving homelessness prevention and rapid rehousing assistance, the household must demonstrate:
 - Lack of resources and support networks. The household must continue to lack sufficient resources and support networks to retain housing without program assistance.
 - Need. The program must determine the amount and type of assistance that the household needs to (re)gain stability in permanent housing.
 - For ESG, at the 12-month annual recertification, the client's income must be at or below 30% Area Median Income.

SERVICE COORDINATION

STANDARD: Programs will assist program participants in obtaining appropriate supportive services and other federal, state, local, and private assistance as needed and/or requested by the household. Program staff will be knowledgeable about mainstream resources and services in the community.

Benchmarks



- Programs should arrange with appropriate community agencies and individuals the provision of education, employment, and training; schools and enrichment programs; healthcare and dental clinics; mental health resources; substance abuse assessments and treatment; legal services, credit counseling services; and other assistance requested by the participant, which programs do not provide directly to clients.
- Programs coordinate with other mainstream resources for which participants may need assistance: emergency financial assistance; domestic violence shelters; local housing authorities, public housing, and Housing Choice Voucher programs; temporary labor organizations; childcare resources and other public programs that subsidize childcare; youth development and child welfare; WIC; Supplemental Nutritional Assistance Program (SNAP); Unemployment Insurance; Social Security benefits; Medicaid/Medicare or other comparable services if available.
- For CoC RRH, in addition to one-time moving costs and case management, other eligible supportive service costs include: childcare, education and employment services, food, housing search and counseling, legal services, life skills training, mental health and outpatient health services, outreach services, substance abuse treatment, transportation, and a one-time utility deposit.

TERMINATION

STANDARD: Termination should be limited to the most severe cases. Programs will exercise sound judgment and examine all extenuating circumstances when determining if violations warrant program termination. BoS recommends programs work with other community service providers to develop a board to hear client grievances.

Benchmarks

Emergency Solutions Grant Homelessness Prevention and Rapid Rehousing

- To terminate assistance to a program participant, the agency must follow the due process provisions set forth in 24 CFR 576.402 as follows:
 - If a program participant violates program requirements, the grantee may terminate the assistance in accordance with a formal process established by the grantee, recognizing the rights of the individuals affected. The grantee must exercise sound judgment and examine all extenuating circumstances in determining when violations warrant termination so that programs terminate assistance to program participants in only the most severe cases.
 - To terminate rental assistance and/or housing relocation and stabilization services to program participants, the required formal process, at a minimum, must consist of:
 - Written notice to the program participant containing a clear statement of the reasons for termination;
 - A review of the decision, in which the program participant has the opportunity to present written or oral objections before a person other than the person who made or approved the termination decision;
 - Prompt written notice of the final decision to the program participant.
 - Termination under this section does not preclude the program from providing further assistance at a later date to the same individual or family.

Continuum of Care Rapid Rehousing, HOME Tenant-Based Rental Assistance



- To terminate assistance to a program participant, the agency must follow the provisions described in 24 CFR 578.91 of the HEARTH Continuum of Care Interim Rule as follows:
 - The grantee may terminate assistance to program participants who violate program requirements or conditions of occupancy. Termination under this section does not preclude the program from providing further assistance at a later date to the same individual or family.
 - To terminate assistance to program participants, the grantee must provide a formal process, recognizing the rights of the individuals receiving assistance under the due process of law. This process, at a minimum, must consist of:
 - Providing program participants with a written copy of program rules and the termination process before the participant begins to receive assistance with copy signed by client;
 - Written notice to program participants containing a clear statement of the reasons for termination;
 - A review of the decision, in which the program participant has the opportunity to present written or oral objections before a person other than the person who made or approved the termination decision;
 - Prompt written notice of the final decision to the program participant.

Supportive Services for Veteran Families – Prevention and Rapid Rehousing

- Limitations on and continuations of the provision of supportive services can be found under 38 CFR 62.35 as follows:
 - *Extremely low-income veteran families*: a participant classified as an extremely low-income veteran family will retain that designation as long as the participant continues to meet all other eligibility requirements.
 - *Limitations on the provisions of supportive services to participants classified under 62.11(c)*: a grantee may provide supportive services to a participant until the earlier of two dates:
 - The participant commences receipt of other housing services adequate to meet the participant's needs;
 - Ninety days from the date the participant exits permanent housing.
 - Supportive services provided to participants classified under 62.11(c) must be designed to support the participants in their choice to transition into housing that is responsive to their individual needs and preferences.
 - *Continuation of supportive services to veteran family member(s)*: if a veteran becomes absent from a household or dies while other members of the veteran family are receiving supportive services, then such supportive services must continue for a grace period following the absence or death of the veteran. The grantee must establish a reasonable grace period for continued participation by the veteran's family member(s), but that period may not exceed 1 year from the date of absence or death of the veteran, subject to the requirements of bullets (1) and (2) of this section. The grantee must notify the veteran's family member(s) of the duration of the grace period.
 - *Referral for other assistance*: if a participant becomes ineligible to receive supportive services under this section, the grantee must provide the participant with information on other available programs and resources.



- *Families fleeing domestic violence*: Notwithstanding the limitations in 62.34 concerning the maximum amount of assistance a family can receive during a defined periods of time, a household may receive additional assistance if it otherwise qualifies for assistance under this part and is fleeing from a domestic violence situation. A family may qualify for assistance even if the veteran is the aggressor or perpetrator of the domestic violence. Receipt of assistance under this provision resets the maximum limitation for assistance under the regulations for the amount of support that can be provided in a given amount of time under 62.34.

FOLLOW-UP SERVICES

STANDARD: Programs must ensure a continuity of services to all clients exiting their programs. Agencies can provide these services directly or through referrals to other agencies.

Benchmarks

- Programs prioritize the development of exit plans for each participant to ensure continued permanent housing stability and connection to community resources as well as a list of prevention and diversion services available if another housing crisis occurs, as desired.
- Programs should attempt to follow up with participants through verbal or written contact at least once 6 months after the client exits the program. A program may provide follow-up services to include identification of additional needs and referral to other agency and community services in order to prevent future episodes of homelessness.

CLIENT AND PROGRAM FILES

STANDARD: Programs will keep all program participant files up-to-date and confidential to ensure effective delivery and tracking of services.

Benchmarks

- Client and program files should, at a minimum, contain all information and forms required by HUD (24 CFR 576.500), the state ESG office, and/or the VA; service plans; case notes; referral lists; and service activity logs, including services provided directly by the homelessness prevention or rapid rehousing program and indirectly by other community service providers. Programs should have:
 - Documentation of homeless status (for RRH) and at-risk of homelessness status (for homelessness prevention).
 - Determination of ineligibility, if applicable, which shows the reason for this determination.
 - Initial and annual income evaluation, per program rules.
 - Program participant records
 - Documentation of using the community's coordinated assessment system.
 - Compliance with shelter and housing standards
 - Services and assistance provided
 - Expenditures and match
 - Conflict of interest/code of conduct policies
 - Homeless participation requirement
 - Faith-based activity requirement, if applicable
 - Other Federal requirements, if applicable



- Confidentiality procedures
- All client information should be entered in the NC HMIS in accordance with data quality, timeliness, and additional requirements found in the agency and user participation agreements. At a minimum, programs must record the date the client enters and exits the program, HUD required data elements, and an update of client's information as changes occur.
- Programs must maintain a release of information form for clients to use to indicate consent in sharing information with other parties. This cannot be a general release but one that indicates sharing information with specific parties for specific reasons.
- Programs must maintain the security and privacy of written client files and shall not disclose any client-level information without written permission of the client as appropriate, except to program staff and other agencies as required by law. Clients must give informed consent to release any client identifying data to be utilized for research, teaching, and public interpretation.
- All records pertaining to ESG funds must be retained for the greater of 5 years or the participant records must be retained for 5 years after the expenditure of all funds from the grant under which the program participant was served. Agencies may substitute original written files with microfilm, photocopies, or similar methods. Records pertaining to other funding sources must adhere to those record retention requirements.

EVALUATION AND PLANNING

STANDARDS: Homelessness prevention and rapid rehousing programs will work with the community to conduct ongoing planning and evaluation to ensure programs continue to meet community needs for individuals and families experiencing homelessness or at-risk of homelessness.

Benchmarks

- Agencies maintain written goals and objectives for their services to meet outcomes required by the HUD CoC and ESG programs or other funding sources. These written goals and objectives should strive to meet these performance benchmarks (for programs serving a high need population such as chronically homeless or no income, the CoC will take targeting efforts into account):
 - Reduce the length of time program participants spend homeless. Households served by the program should move into permanent housing in an average of 30 days or less.
 - Maximize permanent housing success rates. Programs should ensure that at least 80% of households exit to a permanent housing setting.
 - Decrease the number of households returning to homelessness. Programs should ensure that at least 85% of households exiting the program do not become homeless again within one year of exit.
- Programs review case files of clients to determine if existing services meet their needs. As appropriate, programs revise goals, objectives, and activities based on their evaluation.
- Programs conduct, at a minimum, an annual evaluation of their goals, objectives, and activities, making adjustments to the program as needed to meet the needs of the community.



Programs regularly review project performance data in HMIS to ensure reliability of data. Programs should review this information, at a minimum, quarterly



NC Balance of State Continuum of Care Standards Permanent Supportive Housing

OVERVIEW

The NC Balance of State Continuum of Care has developed these program standards to provide specific guidelines for how programs can operate to have the best chance of ending homelessness. These guidelines create consistency across the Balance of State, protect our clients by putting their needs first, and provide a baseline for holding all CoC programs to a specific standard of care.

The Department of Housing and Urban Development (HUD) requires every Continuum of Care to evaluate outcomes of projects funded under the Emergency Solutions Grants program and the Continuum of Care program and report to HUD (24 CFR 578.7(a)7). In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individual and families for housing and services.

In consultation with recipients of ESG and CoC program funds within the geographic area, CoCs must establish and consistently follow written standards for providing CoC assistance. At a minimum, these standards must include:

- Policies and procedures for evaluating individuals' and families' eligibility and determining the process for prioritizing eligible households in emergency shelter, transitional housing, rapid rehousing, and permanent supportive housing programs (24 CFR 578.7(a)(9)).
- For permanent supportive housing programs, program standards to define policies and procedures for prioritization of eligible households.
- Policies and procedures for coordination among emergency shelters, transitional housing programs, essential service providers, homelessness prevention programs, rapid rehousing programs, and permanent supportive housing programs.
- Definitions for participation in the CoC's Homeless Management Information System (or comparable database for domestic violence or victims' service programs).

The Balance of State Continuum of Care developed the following Permanent Supportive Housing program standards to ensure:

- Program accountability to individuals and families experiencing homelessness, specifically populations at greater risk or with the longest histories of homelessness



- Program compliance with the Department of Housing and Urban Development and the Department of Veteran Affairs
- Service consistency within programs
- Adequate program staff competence and training, specific to the target population served

EXPECTATIONS

All program grantees using Department of Housing and Urban Development Continuum of Care and the Department of Veteran's Affairs VA Supportive Housing (VASH) funding must adhere to these performance standards. Programs funded through the Continuum of Care will be monitored by the Balance of State Continuum of Care to ensure compliance. The BoS CoC recommends that permanent supportive housing programs funded through other funding sources also follow these standards. These performance standards attempt to provide a high standard of care that places community and client needs first. Based on proven best practices, this high standard of care is necessary to achieve our goal of ending homelessness in the BoS CoC.

PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing programs provide safe, stable homes through long-term rental assistance, paired with long-term intensive case management services, to highly vulnerable individuals and families with complex issues who are otherwise at risk of serious health and safety consequences from being homeless.¹ This model seeks to provide a stable housing option and the necessary supportive services for individuals and families who would not succeed in other permanent housing settings. Permanent supportive housing is designed for persons with disabilities, including severe mental health, physical health, HIV/AIDS, and/or substance abuse disorders, especially targeting individuals and families meeting the Department of Housing and Urban Development's definition of chronic homelessness. Types of permanent supportive housing include HUD CoC Permanent Supportive Housing, HUD-VASH, and other programs that combine services and rental assistance in the community specifically to house this population.

Successful permanent supportive housing programs use the national best practice called Housing First, the model in which programs house all persons immediately without preconditions such as sobriety, income, or behavioral requirements and pair supportive services matched to the needs of the household.² Long-term studies demonstrate that individuals and families experiencing homelessness, even chronic homelessness, can move into a home with case management, follow a standard lease, and successfully remain in housing over a long period of time. Permanent supportive housing programs with preconditions for entry and overly burdensome program rules cause this high-need population to regularly fail in housing or drive programs to target lower-need individuals who do not need permanent supportive housing programs to successfully remain housed.

¹ <https://www.gpo.gov/fdsys/granule/CFR-2013-title24-vol3/CFR-2013-title24-vol3-part578/content-detail.html>

² <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf>



Permanent supportive housing programs should participate in their Regional Committee's coordinated assessment process, including the local prioritization of individuals for housing. In the BoS CoC, each community utilizes the Prevention and Diversion screening tool and the Individual and Family VI-SPDAT Prescreen Tools to set priorities and housing triage methods, while permanent housing programs use the Case Management Tool for more developed housing placement purposes and for intensive case management over time. Communities use the VI-SPDAT to prioritize individuals and families experiencing homelessness based on an acuity score that indicates the type of housing intervention best suited to their ongoing needs. Permanent supportive housing programs are intended to serve the individuals and families with the longest time homeless and the highest needs.

DEFINITIONS

Acuity: When using the VI-SPDAT prescreens, acuity means the presence of a presenting issue based on the prescreening score. Acuity on the prescreening tool is expressed as a number with the higher score representing more complex, co-occurring issues likely to impact overall stability in permanent housing. When using the Case Management Tool acuity refers to the severity of the presenting issue and the ongoing goals in addressing these issues.

Case Management Tool: A standardized tool for case management to track outcomes in the coordinated assessment process. Housing programs administer this tool at program entry, housing entry, and every six months thereafter until program discharge. Upon discharge from the program, housing case managers administer the tool one final time 12 months later, when possible, to ensure the household continues to make progress.

Chronically Homeless: (1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) had been homeless and living as described in (i) continuously for at least 12 months or on at least 4 occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the care facility; (2) an individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) a family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in (1) or (2) of this definition, including a family whose composition had fluctuated while the head of household has been homeless. (24 CFR 578.3)

Comparable Database: HUD-funded providers of housing and services (recipients of ESG and /or CoC funding) who cannot enter information by law into HMIS (victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database comparable to HMIS. According to HUD, "a comparable database . . . collects client-level data over time and generates unduplicated



aggregate reports based on the data.” The recipient or subrecipient of CoC and ESG funds may use a portion of those funds to establish and operate a comparable database that complies with HUD’s HMIS requirements. (24 CFR 578.57)

Coordinated Assessment: “A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The . . . system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool” (24 CFR 578.3). CoCs have ultimate responsibility to implement coordinated assessment in their geographic area.

Developmental Disability: As defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002): (1) A severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major life activities: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; (v) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (2) an individual from birth to age 9, inclusive, who has a substantial developmental disability or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria in (1)(i) through (v) of the definition of “developmental disability” in this definition if the individual, without services or supports, has a high probability of meeting these criteria later in life. (24 CFR 578.3)

Disabling Condition: According to HUD: (1) a condition that: (i) is expected to be of indefinite duration; (ii) substantially impedes the individual’s ability to live independently; (iii) could be improved by providing more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or a developmental disability, as defined above; or the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from AIDS, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5)

Diversion: Diversion is a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion practices and programs help reduce the number of people becoming homeless and the demand for shelter beds.

Family: A family includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) a single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or (2) a group of persons residing together, and such group includes, but is not limited to: (i) a family with or without children (a child who is temporarily away from the home



because of placement in foster care is considered a member of the family); (ii) an elderly family; (iii) a near-elderly family; (iv) a disabled family; (v) a displaced family; and (vi) the remaining member of a tenant family. (24 CFR 5.403)

Homeless:

Category 1: an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals); or (iii) an individual who exits an institution where he/she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

Category 2: an individual or family who will immediately lose their primary nighttime residence, provided that: (i) the primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) no subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing; or

Category 4: any individual or family who: (i) is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence; (ii) had no other residence; and (iii) lacks the resources or support networks (e.g. family, friends, and faith-based or other social networks) to obtain other permanent housing. (24 CFR 578.3)

Housing First: A national best practice model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment compliance, and service and/or income requirements. Programs offer supportive services to maximize housing stability to prevent returns to homelessness rather than meeting arbitrary benchmarks prior to permanent housing entry.³

Prevention and Diversion Screening Tool: A tool used to reduce entries into the homeless service system by determining a household's needs upon initial presentation to shelter or other emergency response organization. This screening tool gives programs a chance to divert households by assisting them to identify other permanent housing options and, if needed, providing access to mediation and financial assistance to remain in housing.

Rapid Rehousing: A national best practice model designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve long-term

³ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf>



stability. Like Housing First, rapid rehousing assistance does not require adherence to preconditions such as employment, income, absence of criminal record, or sobriety. Financial assistance and housing stabilization services match the specific needs of the household. The core components of rapid rehousing are housing identification/relocation, short- and/or medium-term rental and other financial assistance, and case management and housing stabilization services. (24 CFR 576.2)

Transitional Housing: Temporary housing for participants who have signed a lease or occupancy agreement with the purpose of transitioning participants into permanent housing within 24 months.

VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool): An evidence-based tool used by all regions in the Balance of State to determine initial acuity and set prioritization and intervention for permanent housing placement.

PERSONNEL

STANDARD: Programs shall adequately staff services with qualified personnel to ensure quality of service delivery, effective program administration, and the safety of program participants.

Benchmarks

- The organization selects employees and/or volunteers with adequate and appropriate knowledge, experience, and stability for working with individuals and families experiencing homelessness and/or other issues that place individuals and/or families at risk of homelessness.
- The organization provides time for all employees and/or volunteers to attend webinars and/or trainings on program requirements, compliance, and best practices.
- The organization trains all employees and/or volunteers on program policies and procedures, available local resources, and specific skill areas relevant to assisting clients in the program.
- All paid and volunteer staff participate in ongoing internal and/or external training on the Prevention and Diversion Screening Tool, the individual and family VI-SPDAT screening tool, and the Case Management Tool.
- For programs using the Homeless Management Information System (HMIS), all end users must abide by the NC HMIS End User and Participation Agreements, including adherence to the strict privacy and confidentiality policies.
- Staff supervisors of casework, counseling, and/or case management services have, at a minimum, a bachelor's degree in a human service-related field and/or experience working with individuals and families experiencing homelessness and/or other issues that place individuals and/or families at risk of homelessness.
- Staff supervising overall program operations have, at a minimum, a bachelor's degree in a human service-related field and/or demonstrated ability and experience that qualifies them to assume such responsibility.
- All program staff have written job descriptions that address tasks staff must perform and the minimum qualifications for the position.
- Case managers provide case management with the designated Case Management Tool on a frequent basis (every six months minimum) for all clients.



- Organizations should share and train all program staff on the NC Balance of State Permanent Supportive Housing Written Standards.

PRIORITY FOR TENANTS WHO NEED EMERGENCY TRANSFERS UNDER VAWA 2013

STANDARD: Tenants eligible for emergency transfers under the NC BoS CoC's emergency transfer policy and VAWA statute and regulations have first priority for open permanent supportive housing units, if they also meet all eligibility requirements and relevant prioritization requirements for the PSH project. To access PSH beds dedicated to chronic homelessness, tenants eligible for emergency transfers must also be chronically homeless, unless there is no other option for an emergency transfer in the community and the tenant is otherwise eligible for PSH. Tenants documented as chronically homeless before entering a permanent housing project retain chronic homeless status for the purposes of eligibility for an emergency transfer under VAWA 2013.

ORDER OF PRIORITY FOR CoC-FUNDED DEDICATED OR PRIORITIZED CHRONICALLY HOMELESS BEDS

STANDARD: Programs receiving CoC-funded permanent supportive housing which have dedicated or prioritized their beds to serve individuals and families experiencing chronic homelessness must follow the order of priority in accordance with the Order of Priority section in Notice CPD-16-11⁴ when selecting participants for housing. Grantees must exercise due diligence when conducting outreach and assessment to ensure the program serves people in the order of priority as adopted by the Balance of State Continuum of Care.

Benchmarks

- *First Priority:* Chronically homeless individuals and families as defined in 24 CFR 578.3 with the longest histories of homelessness AND the most severe service needs (as found through the acuity score on the VI-SPDAT with information from community stakeholders).
 - The chronically homeless individual or head of household of a family has experienced homelessness, 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 chronically homeless individual or head of household of a family has severe service needs as assessed through the VI-SPDAT. This person has a history of high utilization of crisis services, including, but not limited to, hospital emergency departments, jail, or psychiatric facilities; or significant health and behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.
- *Second Priority:* Chronically homeless individuals or families with the longest history of homelessness that meet the following:
 - The chronically homeless individual or head of household of a family has experienced homelessness, living in a place not meant for human habitation, a safe

⁴ <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>



- 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 chronically homeless individual or head of household of a family has not been identified to meet the severe service needs described in priority one.
- *Third Priority:* Chronically homeless individuals or families with the most severe service needs.
 - The chronically homeless individual or head of household of a family has experienced homelessness, living in a place not meant for human habitation, a safe haven, or in an emergency shelter 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 but less than others identified in the community needing permanent housing; and
 - The chronically homeless individual or head of household of a family has severe service needs as assessed through the VI-SPDAT. This person has a history of high utilization of crisis services, including, but not limited to, hospital emergency departments, jail, or psychiatric facilities; or significant health and behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.
 - *Fourth Priority:* All other chronically homeless individuals or families.
 - 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 on at least four separate occasions in the last 3 years, where the cumulative total of the four separate occasions is less than 12 months; and
 - The program has not identified the chronically homeless individual or head of household of a family, who meets all of the criteria of a chronically homeless person or family, as having severe service needs.

ORDER OF PRIORITY FOR CoC-FUNDED NON-DEDICATED OR NON-PRIORITIZED CHRONICALLY HOMELESS BEDS

STANDARD: Programs receiving CoC-funded permanent supportive housing that do not dedicate or prioritize their beds for individuals and families experiencing chronic homelessness must first follow the order of priority as mentioned in the section above: Order of Priority for CoC-Funded Dedicated or Prioritized Chronically Homeless Beds. However, if the community does not have any chronically homeless individuals or families or someone meeting the priority listing above cannot be identified within 30 days, programs will prioritize their beds in accordance with the Order of Priority section in Notice CPD-16-11⁵ for non-dedicated or non-prioritized beds when selecting participants for housing.

Benchmarks

- *First Priority:* Priority listing under section: Order of Priority for CoC-Funded Dedicated or Prioritized Chronically Homeless Beds.

⁵ <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>



- *Second Priority:* Homeless individuals and families with a disability with long periods of episodic homelessness and severe service needs.
 - An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months and has been identified as having severe service needs.
- *Third Priority:* Homeless individuals and families with a disability with severe service needs.
 - An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.
- *Fourth Priority:* Homeless individuals and families with a disability coming from places not meant for human habitation, safe havens, or emergency shelters without severe service needs.
 - An individual or family is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.
- *Fifth Priority:* Homeless individuals and families with a disability coming from transitional housing.
 - An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

CLIENT INTAKE PROCESS

STANDARD: Programs will actively participate in their community's coordinated assessment system by only taking referrals from the coordinated assessment system for their program. The program will limit entry requirements to ensure that the program serves the most vulnerable individuals and families needing assistance. The program will ensure active client participation and informed consent.

Benchmarks

- All adult program participants must meet the following program eligibility requirements:
 - Literally homeless or fleeing domestic violence (see definitions above for Category 1 and Category 4 of the Homeless Definition). Some programs have stricter



- participant guidelines and should see their specific program and application information to determine eligibility.
- Programs may require participants to meet only these additional program eligibility requirements if they have targeted specific populations under their grant applications:
 - Chronic homelessness (for CoC-funded PSH that requires chronic homelessness and programs that have committed to prioritize turnover beds to people experiencing chronic homelessness).
 - Homeless veterans (for HUD-VASH programs).
 - Residency requirements (abide by the language of the lease).
 - Programs cannot disqualify an individual or family because of prior evictions, poor rental history, criminal history, or credit history.
 - Programs focus on engaging participants by explaining available services and encouraging each adult household member to participate in said services, but programs do not make service usage a requirement or the denial of services a reason for disqualification or eviction.
 - Programs cannot disqualify an individual or family from program entry for lack of income or employment status.
 - Programs can turn away individuals and families experiencing homelessness from program entry for only the following reasons:
 - Household makeup (provided it does not violate HUD's Fair Housing and Equal Opportunity requirements): singles-only programs can disqualify households with children; families-only programs can disqualify single individuals
 - All program beds are full.
 - If the housing has in residence at least one family member with a child under the age of 18, the program may exclude registered sex offenders and person with a criminal record that includes violent crime from the program so long as the child resides in the same housing facility (24 CFR 578.93)
 - Programs shall use the standard order of priority for documenting evidence to determine homeless status and chronically homeless status per the program's eligibility requirements. Grantees must document in the client file that the agency attempted to obtain the documentation in the preferred order. That order should be as follows:
 - Third-party documentation (including HMIS)
 - Intake worker observations through outreach and visual assessment
 - Self-certification of the person receiving services
 - CoC programs should also assess participant eligibility based on eligibility criteria established by the NOFA for the year of the award.
 - Programs must provide evidence of a diagnosis of one or more of the following conditions (for the CoC program, one adult OR child in the family would qualify): substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a traumatic brain injury, or chronic physical illness or disability. The documentation must include:
 - Written verification of the condition from a professional licensed by the state to diagnose and treat the condition; or
 - Written verification from the Social Security Administration; or
 - Copies of a disability check (e.g. Social Security Disability Insurance check or Veteran



Disability compensation); or



- Intake staff (or referral staff) observation confirmed by written verification of the condition from a professional licensed by the state to diagnose and treat the condition that is confirmed no later than 45 days after the application for assistance and accompanied with one of the types of evidence above; or
- Other documentation approved by HUD or the VA.
- Programs will maintain release of information, case notes, and all pertinent demographic and identifying data in HMIS as allowable by program type. Paper files should be maintained in a locked cabinet behind a locked door with access reserved for case workers and administrators who need said information.

PERMANENT SUPPORTIVE HOUSING

STANDARD: Programs will provide safe, affordable permanent housing that meets participants' needs in accordance with the client intake practices and within CoC established guidelines for permanent supportive housing programs. Programs will pair permanent housing with intensive case management services to participants to ensure long-term housing stability.

Benchmarks

- Programs will meet the key elements of permanent supportive housing published by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration.⁶
- Programs consider the needs of the household in terms of location, cost, number of bedrooms, handicap access, ongoing service needs and other pertinent information when moving a household into housing. Programs will assess potential housing for compliance with program standards for habitability, lead-based paint, and rent reasonableness prior to the individual or family signing a lease.
- Programs provide assistance to the participant in locating and procuring housing.
- For rental assistance or tenant-based rental assistance grants, program participants must sign a lease in their name for a one-year period. For leasing assistance grants, agencies must master lease a unit and then have a sub-lease with the program participant for a one-year period. All participant leases and sub-leases must be standard leases that would apply to any other person leasing said unit and automatically renewable upon expiration for a minimum term of one month. Participant sub-leases with grantees must confer all of the legal rights and protections of the lease between the agency and the landlord.
- HUD CoC grantees will adhere to the responsibilities of grant management outlined by the BoS CoC.⁷
- For CoC-funded permanent supportive housing programs, HUD does not require programs to impose occupancy charges on participants as a condition of residing in the housing (CFR 578.77). However, if programs do require occupancy charges, they must impose them on all participants of the program and these charges cannot exceed the highest of:
 - 30% of the household's monthly adjusted gross income;

⁶ See SAMHSA's Key Elements of PSH: <http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-06-BuildingYourProgram-PSH.pdf>

⁷ See the signature form with responsibilities: <http://www.ncceh.org/files/6274/>



- 10% of the household's monthly income; or
- If the household receives payments for welfare assistance from a public agency wherein part of the payment is for housing costs, the portion of the payment designated for housing costs.
- For CoC programs, PSH assistance must be provided without a designated length of stay.
- For HUD-VASH permanent supportive housing programs, participants must follow rent payment guidelines of the Housing Choice Voucher program.

CASE MANAGEMENT SERVICES

STANDARD: Programs shall provide access to intensive case management services by trained staff to each individual and/or family in the program. Programs should note acceptance or refusal of all services offered in thorough case notes.

Benchmarks (Standard Available Services)

- Programs will meet the key elements of permanent supportive housing published by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration.⁸
- Program staff or other programs connected to the permanent housing program through formal relationship will provide regular and consistent case management to clients based on the individuals' or families' specific needs. This case management should optimally happen at the participants' home whenever possible, or at a minimum, in a convenient place for the participant. Case management includes:
 - Assessing, planning, coordinating, implementing, and evaluating the services delivered to participants.
 - Assisting participants to maintain their permanent housing placement in a safe manner and understand how to get along with fellow residents or neighbors.
 - Helping participants to create strong support networks and participate in the community, as they desire.
 - Using the Case Management Tool for ongoing case management and measurement of acuity over time, determining changes needed to better serve participants.
- Program staff or other programs connected to the permanent housing program through formal relationship will provide basic life skills, including housekeeping, grocery shopping, menu planning and food preparation, consumer education, transportation, and obtaining vital documents (social security cards, birth certificates, school records).
- Program staff or other programs connected to the permanent housing program through formal relationship will assist participants in accessing cash and non-cash income through employment, mainstream benefits, childcare assistance, health insurance, and other sources.

⁸ See SAMHSA's Key Elements of PSH: <http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-06-BuildingYourProgram-PSH.pdf>



- Program staff or other programs connected to the permanent housing program through formal relationship will provide individualized budgeting and money management services to clients as needed.
- Program staff or other program connected to the permanent housing program through formal relationship will provide ongoing assistance with food, clothing, and transportation.
- Programs must assess service needs annually.

Benchmarks (Optional but recommended services, often from other providers)

- Representative payee services.
- Relationship-building and decision-making skills.
- Education services such as GED preparation, post-secondary training, and vocational education.
- Employment services, including career counseling, job preparation, resume-building, dress and maintenance.
- Behavioral health services such as relapse prevention, crisis intervention, medication monitoring and/or dispensing, outpatient therapy and treatment.
- Physical health services such as routine physicals, health assessments, and family planning.
- Legal services related to civil (rent arrears, family law, uncollected benefits) and criminal (warrants, minor infractions) matters.
- For CoC PSH, in addition to the services mentioned such as one-time moving costs and case management, other eligible supportive service costs include childcare, food, housing search and counseling, outreach services, transportation, and one-time utility deposit.

TERMINATION

STANDARDS: Termination should be limited to only the most severe cases. Programs will exercise sound judgment and examine all extenuating circumstances when determining if violations warrant program termination. BoS recommends programs work with other community service providers to develop a board to hear client grievances.

Benchmarks

- Programs will meet the key elements of permanent supportive housing published by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration.⁹
- While violation of a participant's lease or sublease may be cause for termination, programs should develop a termination of services policy giving participants multiple housing chances or work to move participants to a higher-level permanent supportive housing intervention, when possible (i.e. programs will move a participant two times before terminating him/her from services). Programs should only terminate services when clients pose a safety risk to staff or other residents of their community.
 - Programs' goal should be to avoid eviction by working with the landlord and participant to form an agreement allowing participants to move prior to a legal eviction, when possible.

⁹ See SAMHSA's Key Elements of PSH: <http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-06-BuildingYourProgram-PSH.pdf>



- To terminate assistance to a program participant, the agency must follow the provisions described in 24 CFR 578.91 of the HEARTH Continuum of Care Interim Rule as follows:
 - The grantee may terminate assistance to program participants who violate program requirements or conditions of occupancy. Termination under this section does not preclude the program from providing further assistance at a later date to the same individual or family.
 - To terminate assistance to program participants, the grantee must provide a formal process, recognizing the rights of the individuals receiving assistance under the due process of law. This process, at a minimum, must consist of:
 - Providing program participants with a written copy of program rules and the termination process before the participant begins to receive assistance with a copy signed by the participant in the file;
 - Written notice to program participants containing a clear statement of the reasons for termination.
 - A review of the decision, in which the program participant has the opportunity to present written or oral objections before a person other than the person who made or approved the termination decision; and
 - Prompt written notice of the final decision to the program participant.
- Programs should not immediately terminate participants who enter an institution (medical, mental health, or crisis). HUD CoC PSH grants allow grantees to maintain open units for institutionalized individuals and families for up to 90 days.

EXITING AND FOLLOW-UP SERVICES

STANDARD: Programs must ensure a continuity of services to all clients exiting their programs, including those individuals and families terminated from the program. Agencies can provide these services directly or through referrals to other agencies.

Benchmarks

- Programs prioritize the development of exit plans for each participant to ensure continued permanent housing stability and connection to community resources, as desired.
- Programs routinely check in with PSH participants to identify those households whose acuity scores are low enough to maintain permanent housing stability in market rate or subsidized housing outside the permanent supportive housing program.
- Programs develop a plan, in conjunction with the participating household, for effective, timely exit of individuals and families whose acuity scores are low enough to maintain permanent housing stability in market rate or subsidized housing outside the permanent supportive housing program.
- Programs should attempt to follow up with participants through verbal or written contact at least once 6 months after the client exits the program. A program may provide follow-up services to include identification of additional needs and referral to other agency and community services in order to prevent future episodes of homelessness.
- For HUD CoC PSH grants, programs may provide services to formerly homeless individuals and families for up to six months after their exit from the program.

CLIENT AND PROGRAM FILES



STANDARD: Programs will keep all program participant files up-to-date and confidential to ensure effective delivery and tracking of services.

Benchmarks

- Client and program files should, at a minimum, contain all information and forms required by HUD (24 CFR 576.500), and the VA, service plans, case notes, referral lists, and service activity logs, including services provided directly by the permanent supportive housing program and indirectly by other community service providers. Programs should have:
 - Documentation of homeless status, chronic homelessness status (where applicable), and disabling condition.
 - Determination of ineligibility, if applicable, which shows the reason for this determination.
 - Initial and annual income evaluation, per program rules.
 - Program participant records.
 - Documentation of using the community's coordinated assessment system.
 - Compliance with shelter and housing standards.
 - Services and assistance provided.
 - Expenditures and match.
 - Conflict of interest/code of conduct policies.
 - Homeless participation requirement.
 - Faith-based activity requirement, if applicable.
 - Other Federal requirements, if applicable.
 - Confidentiality procedures.
- All client information should be entered in the NC HMIS in accordance with data quality, timeliness, and additional requirements found in the agency and user participation agreements. At a minimum, programs must record the date the client enters and exits the program, HUD required data elements, and an update of client's information as changes occur.
- Programs must maintain a release of information form for clients to use to indicate consent in sharing information with other parties. This cannot be a general release but one that indicates sharing information with specific parties for specific reasons.
- Programs must maintain the security and privacy of written client files and shall not disclose any client-level information without written permission of the client as appropriate, except to program staff and other agencies as required by law. Clients must give informed consent to release any client identifying data to be utilized for research, teaching, and public interpretation.
- All records pertaining to CoC funds must be retained for the greater of 5 years or the participant records must be retained for 5 years after the expenditure of all funds from the grant under which the program participant was served. Agencies may substitute original written files with microfilm, photocopies, or similar methods. Records pertaining to other funding sources must adhere to those record retention requirements.

EVALUATION AND PLANNING

STANDARD: Permanent supportive housing programs will work with the community to conduct ongoing planning and evaluation to ensure programs continue to meet community needs for individuals and families experiencing homelessness.



Benchmarks

- Agencies maintain written goals and objectives for their services to meet outcomes required by the HUD CoC and VA programs or other funding sources.
- Programs review case files of clients to determine if existing services meet their needs. As appropriate, programs revise goals, objectives, and activities based on their evaluation.
- Programs conduct, at a minimum, an annual evaluation of their goals, objectives, and activities, making adjustments to the program as needed to meet the needs of the community.
- Programs regularly review project performance data in HMIS to ensure reliability of data. Programs should review this information, at a minimum, quarterly.



NC Balance of State Continuum of Care System Standards Coordinated Assessment

Overview

The NC Balance of State Continuum of Care has developed these system standards to give specific guidelines for how best to operate regional coordinated assessment systems to achieve the goal of ending homelessness. These guidelines create consistency across the Balance of State regions, protect our mutual clients by putting their needs first, and provide a baseline for holding all CoC coordinated assessment systems to a specific standard of care.

The Department of Housing and Urban Development (HUD) requires every Continuum of Care to evaluate outcomes of projects funded under the Emergency Solutions Grants program and the Continuum of Care program and report to HUD (24 CFR 578.7(a)7). In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individual and families for housing and services.

- In consultation with recipients of ESG and CoC program funds within the geographic area, CoCs must establish and consistently follow written standards for providing CoC assistance. At a minimum, these standards must include: Policies and procedures for evaluating individuals' and families' eligibility for and determining the process for prioritizing eligible households in transitional housing, rapid rehousing, and permanent supportive housing programs.
- Policies and procedures for coordination among emergency shelters, transitional housing programs, essential service providers, homelessness prevention programs, rapid rehousing programs, and permanent supportive housing programs.
- Definitions for participation in the CoC's Homelessness Management Information System (or comparable database for domestic violence or victims' service programs).

The Balance of State Continuum of Care developed coordinated assessment system standards to ensure:

- System accountability to individuals and families experiencing homelessness, specifically populations at greater risk or with the longest histories of homelessness
- System compliance with the Department of Housing and Urban Development
- Consistency across regional coordinated assessment systems
- Adequate staff competence and training, specific to the target population served

COORDINATED ASSESSMENT

Coordinated assessment systems allow CoCs to coordinate program participant intake, assessment, and provision of referrals. The system covers a set geographic area, can be easily accessed by individuals and families experiencing homelessness or at-risk of homelessness seeking housing and services, is well advertised, and includes a comprehensive and standardized



assessment tool.⁵

Any community can implement a coordinated assessment system regardless of geography, housing resources, service availability, or unique community makeup. Communities can successfully create and operate coordinated assessment with patience, persistence, testing, and revisions.

Whether a CoC, community or region uses the terms “coordinated assessment,” “coordinated access,” “centralized intake,” or “coordinated intake,” the substance behind the name remains the same: transitioning from a “first come, first served” mentality to one that prioritizes the most vulnerable individuals and families in a community for the most intensive interventions and sets a course of services that meets the needs of all individuals and families experiencing homelessness or at-risk of homelessness.

Coordinated assessment, when implemented correctly, prioritizes individuals and families who need housing the most across communities. This type of system moves beyond programs to create a collaborative environment across all services and program types in the community that can provide an informed way to target housing and supportive services to:

- Divert people away from the system who have other safe options for housing.
- Quickly move people from homelessness to permanent housing by connecting them to the most appropriate housing program available.
- Create a more effective and defined role for emergency shelters and transitional housing.
- Save time, effort, and frustration on the part of service providers through targeting and engagement efforts.
- Focus on efforts of ending homelessness as a community.
- Reduce the length of time homeless by moving people quickly into the appropriate housing.
- Increase the likelihood of housing stability by targeting the appropriate housing intervention to corresponding needs.
- Provide a picture of current system gaps in the community that need to be filled in order to end homelessness for all households
- Be good stewards of limited resources.

Traditionally, communities did not have an organized, transparent system for entry and referral to housing and support services. Individual programs served only people presenting themselves at their front doors, taking clients on a “first come, first served” basis. While many communities still operate in this manner, years of research, re-thinking, and commitment to moving away from this linear approach, has shifted communities towards a collaborative systematic approach.⁶ These changes include:

Historic Practice is Program-Centric

Coordinated Assessment is Client-Centric

⁵ <https://www.gpo.gov/fdsys/granule/CFR-2013-title24-vol3/CFR-2013-title24-vol3-part578/content-detail.html>

⁶ <http://www.endhomelessness.org/library/entry/one-way-in-the-advantages-of-introducing-system-wide-coordinated-entry-for->



Should we accept this person into our program?	What housing and service intervention is the best fit for each individual or family?
Clients must tell their information to every program that they enter for services	Standard forms, assessment, and intake processes across all programs in the community
Uneven knowledge about existing programs, eligibility, and purpose in communities	Accessible information about housing and service options in the CoC, community or region

Building a strong coordinated assessment system builds on and enhances the strengths of the community's programs. When communities come together to implement coordinated assessment, each program realizes success in multiple ways:

- *Programs receive eligible clients:* Programs receive appropriate referrals for participants whose needs and eligibility have already been determined.
- *Case managers can do case management:* When every program does their own intake, case managers often share most of this burden. When communities use a common assessment to share this workload, staff can realize real efficiencies in housing placement and case management.
- *Communities understand the resources they need most:* When communities coordinate the front door of their system, they begin to see who is accessing homeless and housing services and what their needs are. With this understanding, communities can begin to right-size their system to ensure that programs are there to meet the needs of households accessing the system.
- *Time, red-tape, and barriers are significantly reduced:* When community programs follow the same process and understand one another's roles, workload is reduced for everyone.

NC BALANCE OF STATE COORDINATED ASSESSMENT GUIDING PRINCIPLES

Across the NC BoS, all locally designed and operated coordinated assessment systems will be:

- *Sustainable:* Regional Committees identify the resources required to operate a coordinated assessment system now and for the foreseeable future.
- *Flexible:* Communities customize their coordinated assessment system based on community needs, resources, and services available.
- *Transparent and accountable:* Participants understand what coordinated assessment is doing and why. Agencies publish and make available their program rules and have a clear, fair grievance and appeals process for both participants and services agencies.
- *Housing-focused:* Individuals and families experiencing homelessness return to permanent housing within an average of 30 days, in compliance with HEARTH.
- *Client-focused:* The coordinated assessment system is easily accessible, leaves no one behind, and accommodates participant choice and needs.
- *Collaboration-focused:* Regional Committees operate their systems with broad-based consensus and manage system responsibilities through strong partnerships where integrity is key and service providers hold one another accountable and exhibit a willingness to cooperate.

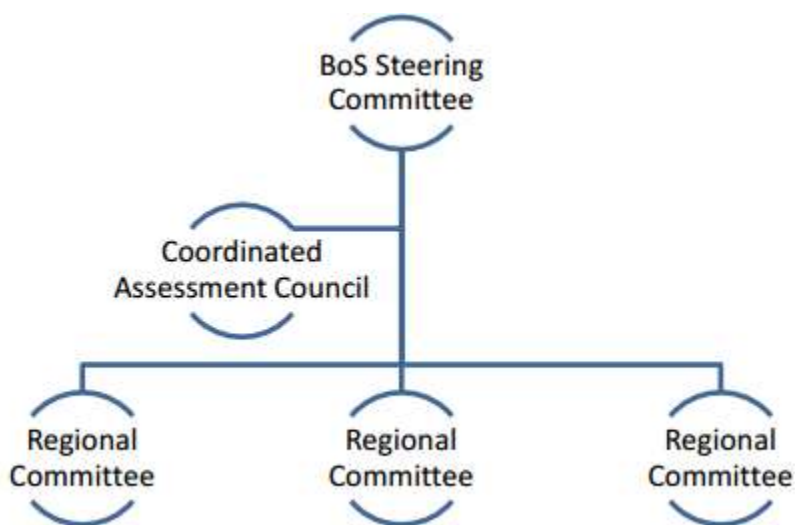


- *Easy-to-use:* System is well-advertised and known throughout the community. It does not inhibit providers from doing their job of ending homelessness.
- *Accessible:* The coordinated assessment system is accessible to every individual and family experiencing homelessness or at-risk of homelessness, regardless of race, color, national origin, religion, sex, age, familial status, disability, or sexual orientation, gender identity or marital status.

GOVERNANCE

General Structure

Local Regional Committees will design and administer coordinated assessment in their communities with standards and governance provided by the NC BoS Steering Committee. The Steering Committee will appoint a standing Coordinated Assessment Council (CAC) to approve new Regional Committee coordinated assessment plans and significant ongoing changes. The CAC will have representatives from across the Balance of State and other state-level experts.



Role of Coordinated Assessment Council (CAC)

The BoS Steering Committee appoints members to the Coordinated Assessment Council. The CAC provides oversight of the full CoC's coordinated assessment system to ensure regional coordinated assessment plans meet the standards set forth in this document. The CAC approves significant plan changes and provides ongoing oversight of the full system to meet Department of Housing and Urban Development priorities and mandates.

Role of Regional Committees

Each Regional Committee will design and implement a local coordinated assessment system within the parameters of the system standards provided. The standards give Regional Committees a supportive framework to use when implementing local systems as well as standardized assessment tools that will be uniform across the BoS CoC. These tools include: the Prevention and Diversion screening tool, the Individual and Family VI-SPDAT Screening Tools, and the Case Management Tool. This document describes these assessments in the definitions section and demonstrates their use throughout the document.



DEFINITIONS

Acuity: When using the VI-SPDAT prescreens, acuity means the presence of a presenting issue based on the prescreening score. Acuity on the prescreening tool is expressed as a number with the higher score representing more complex, co-occurring issues likely to impact overall stability in permanent housing. When using the Case Management Tool acuity refers to the severity of the presenting issue and the ongoing goals to addressing these issues.

Case Management Tool: A standardized tool for case management to track participant progress in programs in the coordinated assessment process. Housing programs administer this tool at program entry, housing entry, and every six months thereafter until program discharge. Upon discharge from the program, housing case managers administer the tool one final time 12 months later, when possible, to ensure the household continues to make progress.

Chronically Homeless: (1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) had been homeless and living as described in (i) continuously for at least 12 months or on at least 4 occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the care facility; (2) an individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) a family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in (1) or 2) of this definition, including a family whose composition had fluctuated while the head of household has been homeless. (24 CFR 578.3)

Comparable Database: HUD-funded providers of housing and services (recipients of ESG and /or CoC funding) who cannot enter information by law into HMIS (victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database comparable to HMIS. According to HUD, “a comparable database . . . collects client-level data over time and generates unduplicated aggregate reports based on the data.” The recipient or subrecipient of CoC and ESG funds may use a portion of those funds to establish and operate a comparable database that complies with HUD’s HMIS requirements. (24 CFR 578.57)

Coordinated Assessment: “A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The . . . system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool” (24 CFR 578.3). CoCs have ultimate responsibility to implement coordinated assessment in their geographic area.



Developmental Disability: As defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002): (1) A severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major life activities: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; (v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (2) an individual from birth to age 9, inclusive, who has a substantial developmental disability or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria in (1)(i) through (v) of the definition of "developmental disability" in this definition if the individual, without services or supports, has a high probability of meeting these criteria later in life. (24 CFR 578.3)

Disabling Condition: According to HUD: (1) a condition that: (i) is expected to be of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by providing more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or a developmental disability, as defined above; or the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from AIDS, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5)

Diversion: Diversion is a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion practices and programs help reduce the number of people becoming homeless and the demand for shelter beds.

Family: A family includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) a single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person: or (2) a group of persons residing together, and such group includes, but is not limited to: (i) a family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) an elderly family; (iii) a near-elderly family; (iv) a disabled family; (v) a displaced family; and (vi) the remaining member of a tenant family. (24 CFR 5.403)

Homeless:

Category 1: an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to



provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals); or (iii) an individual who exits an institution where he/she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

Category 2: an individual or family who will immediately lose their primary nighttime residence, provided that: (i) the primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) no subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing; or

Category 4: any individual or family who: (i) is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence; (ii) had no other residence; and (iii) lacks the resources or support networks (e.g. family, friends, and faith-based or other social networks) to obtain other permanent housing. (24 CFR 578.3)

Housing First: A national best practice model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment compliance, and service and/or income requirements. Programs offer supportive services to maximize housing stability to prevent returns to homelessness rather than meeting arbitrary benchmarks prior to permanent housing entry.⁷

Prevention and Diversion Screening Tool (aka Emergency Response Screening): A tool used to reduce entries into the homeless service system by determining a household's needs upon initial presentation to shelter or other emergency response organization. This screening tool gives programs a chance to divert households by assisting them to identify other permanent housing options and, if needed, providing access to mediation and financial assistance to remain in housing.

Rapid Rehousing: A national best practice model designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve long-term stability. Like Housing First, rapid rehousing assistance does not require adherence to preconditions such as employment, income, absence of criminal record, or sobriety. Financial assistance and housing stabilization services match the specific needs of the household. The core components of rapid rehousing are housing identification/relocation, short- and/or medium-term rental and other financial assistance, and case management and housing stabilization services. (24 CFR 576.2)

Transitional Housing: Temporary housing for participants who have signed a lease or occupancy agreement with the purpose of transitioning participants into permanent housing within 24 months.

⁷ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf>



VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool): An evidence-based tool used by all regions in the Balance of State to determine initial acuity and set prioritization and intervention for permanent housing placement.

ORDER OF PRIORITY FOR CoC-FUNDED DEDICATED OR PRIORITIZED CHRONICALLY HOMELESS BEDS

STANDARD: Programs receiving CoC-funded permanent supportive housing which have dedicated or prioritized their beds to serve individuals and families experiencing chronic homelessness must follow the order of priority in accordance with the Order of Priority section in Notice CPD-16-11⁸ when selecting participants for housing. Grantees must exercise due diligence when conducting outreach and assessment to ensure the program serves people in the order of priority as adopted by the Balance of State Continuum of Care.

Benchmarks

- *First Priority:* Chronically homeless individuals and families as defined in 24 CFR 578.3 with the longest histories of homelessness AND the most severe service needs (as found through the acuity score on the VI-SPDAT with information from community stakeholders).
 - The chronically homeless individual or head of household of a family has experienced homelessness, 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 chronically homeless individual or head of household of a family has severe service needs as assessed through the VI-SPDAT. This person has a history of high utilization of crisis services, including, but not limited to, hospital emergency departments, jail, or psychiatric facilities; or significant health and behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.
- *Second Priority:* Chronically homeless individuals or families with the longest history of homelessness that meet the following:
 - The chronically homeless individual or head of household of a family has experienced homelessness, 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 chronically homeless individual or head of household of a family has not been identified to meet the severe service needs described in priority one.
- *Third Priority:* Chronically homeless individuals or families with the most severe service needs.
 - The chronically homeless individual or head of household of a family has experienced homelessness, living in a place not meant for human habitation, a safe haven, or in an emergency shelter 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 but less than others identified in the community needing permanent housing; and

⁸ <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>



- The chronically homeless individual or head of household of a family has severe service needs as assessed through the VI-SPDAT. This person has a history of high utilization of crisis services, including, but not limited to, hospital emergency departments, jail, or psychiatric facilities; or significant health and behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.
- *Fourth Priority:* All other chronically homeless individuals or families.
 - 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 on at least four separate occasions in the last 3 years, where the cumulative total of the four separate occasions is less than 12 months; and
 - The program has not identified the chronically homeless individual or head of household of a family, who meets all of the criteria of a chronically homeless person or family, as having severe service needs.

ORDER OF PRIORITY FOR CoC-FUNDED NON-DEDICATED OR NON-PRIORITIZED CHRONICALLY HOMELESS BEDS

STANDARD: Programs receiving CoC-funded permanent supportive housing that do not dedicate or prioritize their beds for individuals and families experiencing chronic homelessness must first follow the order of priority as mentioned in the section above: Order of Priority for CoC-Funded Dedicated or Prioritized Chronically Homeless Beds. However, if the community does not have any chronically homeless individuals or families or someone meeting the priority listing above cannot be identified within 30 days, programs will prioritize their beds in accordance with the Order of Priority section in Notice CPD-16-11⁹ for non-dedicated or non-prioritized beds when selecting participants for housing.

Benchmarks

- *First Priority:* Priority listing under section: Order of Priority for CoC-Funded Dedicated or Prioritized Chronically Homeless Beds.
- *Second Priority:* Homeless individuals and families with a disability with long periods of episodic homelessness and severe service needs.
 - An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months and has been identified as having severe service needs.
- *Third Priority:* Homeless individuals and families with a disability with severe service needs.
 - An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

⁹ <https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>



- **Fourth Priority:** Homeless individuals and families with a disability coming from places not meant for human habitation, safe haven, or emergency shelters without severe service needs.
 - An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.
- **Fifth Priority:** Homeless individuals and families with a disability coming from transitional housing.
 - An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

CLIENT INTAKE PROCESS THROUGH COORDINATED ASSESSMENT

PROCESS: Regional Committees determine whether their coordinated assessment system will be *centralized* (designated agency or agencies within their community to handle intake and referrals) or *decentralized* (all agencies will employ the common assessment and referral system for intake). All programs will actively participate in their Regional Committee's coordinated assessment system. Programs will minimize their entry requirements to ensure that the most vulnerable individuals and families experiencing homelessness are served. CoC and ESG housing programs will not accept referrals for housing outside of their community's coordinated assessment system. Communities will use the Prevention and Diversion screening tool prior to entry into shelter and emergency housing programs. Once entered into shelter or emergency housing after a length of time to be determined in the community, programs will administer the VI-SPDAT Screening Tool to determine the most appropriate housing intervention based on the individual's or family's specific needs and acuity.

STEPS:

1. All adult program participants must meet eligibility requirements by appropriate program.
2. Programs may require participants to meet only additional program eligibility requirements as they relate specifically to federally, state-guided, and Continuum of Care eligibility in writing.
3. The only reasons programs may disqualify an eligible individual or family from program entry are:
 - a. All programs beds are full.
 - b. If the housing has in residence at least one family member with a child under the age of 18, the program may exclude registered sex offenders and person with a criminal record that includes violent crime from the program so long as the child resides in the same housing facility (24 CFR 578.93).



4. Programs cannot disqualify an individual or family from program entry for lack of income or employment status.
5. Programs cannot disqualify an individual or family because of prior evictions, poor rental history, criminal history, or credit history.
6. Programs cannot disqualify an individual due to the type or extent of disability-related services or supports that are needed or due to active or a history of substance use.
7. Programs explain available services and encourage each adult household member to participate in program services, but do not make service usage a requirement or the denial of services a reason for disqualification or eviction.
8. All client information should be entered in the NC HMIS in accordance with data quality, timeliness, and additional requirements found in the agency and user participation agreements. At a minimum, programs must record the date the client enters and exits the program, HUD required data elements, and an update of client’s information as changes occur.

TOOLS

Having the standardized tools to operate a coordinated assessment is necessary to successfully implement the system. The following list shows the necessary tools and the specific ones used by all Regional Committees in the NC Balance of State Continuum of Care.

Tool of Concept	Specific solution used by the NC BoS CoC
A common prevention tool at entry prior to entry in the homeless service system	Prevention and Diversion Screening Tool
A common assessment tool at entry to determine the best housing intervention	Individual and Family VI-SPDATs V.2
A common process for prioritization for housing	Regional Committees determine their scoring ranges for the various housing interventions
A common referral mechanism across programs	Regional Committees determine the common mechanism used within their communities <i>Future: ServicePoint in HMIS for the VI-SPDAT</i>
A common community-level process for housing placement	Regional Committees determine the community-level process which may include local prioritization meetings and shared prioritization lists
A common tool for case management and housing stabilization	Case Management Tool
A common method to measure results of the process	Quarterly Coordinated Assessment Reports

ASSESSMENT

PROCESS: All programs will actively participate in their Regional Committee’s coordinated assessment system by sharing responsibilities for implementing the system and closing side doors that circumvent the coordinated assessment process. All Regional Committees will use the



Prevention and Diversion screening tool as the initial triage assessment for coordinated assessment. Whenever possible, Regional Committees want to work to divert any individual or family from the homeless service system by providing problem-solving, mediation, and diversion financial assistance to presenting households. When diversion is not possible, programs administering the Prevention and Diversion screen should refer clients to appropriate emergency services to meet their needs. Once in the shelter or emergency housing system communities will then administer the Individual or Family VI-SPDAT after the Regional Committee's agreed-upon waiting period. Programs should submit their VI-SPDAT scores through the agreed-upon method so that individuals and families can be evaluated, prioritized, and slated for the appropriate housing intervention.

STEPS:

1. All staff and/or volunteers administering the Prevention and Diversion screening tool, the Individual and Family VI-SPDAT Screening Tools, and the Case Management Tool should participate in training prior to direct work with individuals and families presenting for services.
 - a. The Prevention and Diversion Screening Tool can be found at: <https://prezi.com/3swi9bhxszd/prevention-and-diversion-screen-version-2/>
 - b. The VI-SPDAT Screening Tools can be found at: https://prezi.com/ebmxox_3qwqd/vi-spdatt-version-2/
2. [The coordinated assessment system must not screen out anyone due](#) to perceived barriers related to housing or services, including, but not limited to, too little or no income, active or a history of substance use, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record—with exceptions for state or local restrictions that prevent projects from serving people with certain convictions.
3. All Regional Committees will use the Prevention and Diversion screening tool as the initial triage assessment, diverting households as possible using problem-solving, mediation, and/or financial assistance. If a household cannot be assessed with the Prevention and Diversion screen immediately, though, they should not be prevented from entering shelter or receiving other emergency services.
4. Once individuals and families enter the homeless service system, programs should administer the Individual or Family VI-SPDAT to households that have reached the agreed-upon community time limit with a suggested waiting period of two weeks. Once complete, the VI-SPDAT provides programs with the ability to determine, across dimensions, the acuity of an individual or family. Street outreach programs may choose to administer the VI-SPDAT on a different timeline to unsheltered households, as needed.
5. The VI-SPDAT, like all evidence-informed common assessment tools, expresses acuity of an individual or family through a numeric score, with a higher number representing more complex, co-occurring disorders likely to impact overall housing stability. In administering the VI-SPDAT, communities cannot require the disclosure of specific disabilities or diagnoses. The VI-SPDAT score shows the *presence* of these issues and indicates the potential best intervention for housing and services. The assessment tool bases the score on the following:
 - a. Wellness: Chronic health issues and substance abuse
 - b. Socialization and Daily Functioning: Meaningful daily activities, social supports, and income



- c. History of Housing and Homelessness: Length of time experiencing homelessness and cumulative incidences of homelessness
 - d. Risks: Crisis, medical and law enforcement interdictions. Coercion, trauma, and most frequent places the individual or family has slept
 - e. Family Unit (Family VI-SPDAT only): School enrollment and attendance, familial interaction, family makeup, and childcare
6. Regional Committees must have a process by which they operate prioritization lists within their coordinated assessment system that eliminates a “first come, first served” status quo and prioritizes individuals and families based on acuity and NC BoS CoC prioritization policies. Within acuity, when participants have the same score, Regional Committees should have a written schedule of priorities based on length of time homeless, vulnerability, and community needs (i.e. unsheltered before sheltered, families before individuals, or fleeing domestic violence before non-domestic violence). Prioritization lists may not prioritize households based on a diagnosis or particular disability or another other protected status.
 7. Scores on the VI-SPDAT populate the local prioritization list, allowing Regional Committee agencies, providers, case managers, and others with housing resources to decide who enters housing next by acuity. Length of time homeless should also be tracked by Regional Committees in order to follow the prioritization listing above. Communities may also track eligibility factors that can determine referrals (e.g. veteran status). Communities may track specific diagnosis or disability information if it is necessary to determine eligibility, and as long as eligibility information is not being used as part of the prioritization or ranking.
 8. Regional Committees may use additional prioritization factors such as high utilization of crisis or emergency services, unsheltered status, risk of continued homelessness, or vulnerability to victimization. Regional committees may not use other factors that would discriminate based on race, color, religion, national origin, sex, age, familial status, disability, type or amount of disability, disability-related services or supports required or actual or perceived sexual orientation, gender identity, or marital status.

Regional Committees determine the VI-SPDAT score range under which individuals and families experiencing homelessness go into various housing interventions based on community needs. However, the score ranges below are recommended for communities and serve as a good starting point for any community initially implementing coordinated assessment.

VI-SPDAT Individuals V.2

Intervention Recommendation	VI-SPDAT Prescreen Score for Individuals
Permanent Supportive Housing	10-20
Rapid Rehousing	5-9
Basic Case Management	0-4

VI-SPDAT Families V.2

Intervention Recommendation	VI-SPDAT Prescreen Score for Families
Permanent Supportive Housing	12-20



Rapid Rehousing	6-11
Basic Case Management	0-5

ASSIGN WITH CLIENT CHOICE

PROCESS: Programs will provide safe, affordable housing meeting participants' needs in accordance with the coordinated assessment process and prioritization schedule, based on acuity and eligibility. Programs will provide rapid and successful entry into permanent housing for each eligible household, by acuity, with as few barriers as possible. The coordinated assessment system will focus its attention on the ability of all clients in the community to access the appropriate housing intervention.

STEPS:

1. In providing or arranging for housing, programs consider the specific household needs of the individual or family experiencing homelessness.
2. Programs assist households in finding suitable housing quickly and effectively and do so guided by client input and choice.
3. Programs agree to only accept referrals through the coordinated assessment system, closing all side doors to permanent housing placement.

Client choice should remain at the center of any referral and placement, with the client being completely informed of the steps and processes necessary to move from homelessness to permanent housing. Local Regional Committees decide how the referral process will work in their communities. However, the process should include, whenever possible, a warm hand-off of the client to the referred agency, which could include either a phone call or email with a method for transmitting intake materials including the completed prevention and diversion screen and/or the VI-SPDAT. If a client rejects the program to which they are referred, they should maintain their place on the community-wide waitlist. Communities should take into consideration resources for transportation to get clients from screening site to referred agency.

FOLLOW-UP AND HOUSING STABILIZATION

PROCESS: To reduce returns to homelessness, programs should provide a continuity of services to all participants following their exit from a program. These services may be provided directly by the program or through referrals to other service providers.

STEPS:

1. Programs prioritize the development of exit plans for each participant to ensure continued permanent housing stability and connection to community resources, as desired.
2. Programs routinely check in with PSH participants to identify those households whose acuity scores are low enough to maintain permanent housing stability in market rate or subsidized housing outside the permanent supportive housing program.
3. Programs develop a plan, in conjunction with the participating household, for effective, timely exit of individuals and families whose acuity scores are low enough to maintain permanent housing stability in market rate or subsidized housing outside the permanent supportive housing program.



4. Programs should attempt to follow up with participants through verbal or written contact at least once 6 months after the client exits the program. A program may provide follow-up services to include identification of additional needs and referral to other agency and community services in order to prevent future episodes of homelessness.
5. For HUD CoC PSH grants, programs may provide services to formerly homeless individuals and families for up to six months after their exit from the program.

Programs will use the Case Management Tool, a standardized tool for case management, to track household progress in meeting key needs and determine ongoing acuity of the participant household. Programs begin administering the Case Management Tool at program entry, at housing entry, and every 6 months thereafter until program discharge. Programs should use this tool during the follow-up with participants 6 months after program exit to ensure that the household continues to thrive in permanent housing and can assist with service referral if the acuity score indicates ongoing needs.

Programs should train all staff members who will administer the Case Management Tool or who will supervise case management staff who administer the tool. An online video training can be found at: https://prezi.com/adwfk2xzig_/case-management-tool-version-2/.

Regional Committees determine the Case Management Tool score range under which individuals and families in permanent housing programs should be considered for exit to another permanent housing program or housing subsidy based on community resources, keeping in mind that some households may experience ongoing challenges at program exit.

ACCOUNTABILITY

PROCESS: Programs should actively contribute to their local coordinated assessment system and prioritization process. Both HUD and VA programs must participate and only accept referrals from the local system. When potential participants contact programs, according to their system, they should assess the household at a point of entry into the system or refer the household to the designated coordinated assessment agency in their community. All coordinated assessment systems must have a grievance process for participants and agencies using the system to formally bring their concerns to the Regional Committee.

STEPS:

1. Regional Committees must ensure that all providers serving individuals and families experiencing homelessness or at-risk of homelessness have been invited to participate in the local coordinated assessment system. For providers unwilling to play a role, Regional Committees must consistently outreach and engage these providers to reconsider their role with coordinated assessment.
2. Regional Committees should ensure that all counties under their purview play a role in the coordinated assessment system either through a central system for the entire area or individual county systems that coordinate with one another on participant referral and service/permanent housing access.
3. Programs should make every effort to take as many referrals from their local prioritization process as possible within federal and state eligibility criteria. If programs exhibit a consistent



history of turning down referrals, the coordinated assessment system should reach out to said programs to encourage them to lower barriers to entry. Communities are able to set a limit of the number of referrals that participating programs can deny.

4. Regional Committees must submit quarterly outcome reports to the BoS Coordinated Assessment Council. These reports are due on the 15th of the month after quarter end: April 15th, July 15th, October 15th, and January 15th. The quarterly report can be accessed at: <http://bit.ly/29UYXuR>.
5. Regional Committees must create a grievance process for participants and agencies using the system when they have a concern with decisions made by the coordinated assessment system or agencies operating under said system. Local grievance procedures will handle the majority of issues. For issues that the local system cannot resolve, participants and/or agencies can appeal their concern to the BoS Coordinated Assessment Council for resolution. Documentation about the grievances filed and resolved should be kept by the community.
6. Regional Committees should evaluate the effectiveness of their coordinated assessment systems on a regular basis, using their own data and the reflection of the quarterly visual report provided from the BoS Coordinated Assessment Council (CAC). Regional Committees should make changes to their system that can make them more effective. Some changes require CAC approval, which include:
 - a. Referral mechanism/process
 - b. Waitlist mechanism/process
 - c. Stop/start using HMIS for coordinated assessment
 - d. Changes to assessment tools

Regional Committees should request to make these changes through the following form: <http://bit.ly/29Ym8ID>

Privacy Protections

All participants in Coordinated Assessment must be informed of how their information collected during the Coordinated Assessment process would be shared and used and must provide consent before that information is shared. Each Regional Committee should establish a community-wide release of information that each participant signs before their information is shared.

Participants in Coordinated Assessment must be allowed to refuse to have their information shared or refuse to disclose certain information. Regional Committees cannot deny services to participants if participants refuse to share or disclose information, unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.

The assessment and prioritization process cannot require disclosure of specific disabilities or diagnoses. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

Safety Planning

The coordinated assessment system must ensure the safety of people fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault, and victims of trafficking.



People administering the Prevention and Diversion Screening must always follow the domestic violence protocol, which directs agencies to refer clients directly to victim service providers immediately if they indicate they may be fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault or are victims of trafficking.

If victim service providers are participating in the Regional Committee's coordinated assessment process, their clients must be tracked confidentially, without divulging any information that could put their safety at risk, including, but not limited to, personally identifying information.

Victim service providers may instead use an alternative coordinated assessment system, as long as it meets all of HUD's minimum requirements. If victim service providers would like to use an alternative system, they should contact their regional coordinated assessment lead as well as NCCFH staff to help design that system.

Non-Discrimination and Equal Access

Participants may not be denied access to the coordinated assessment process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault, stalking, or human trafficking.

The coordinated entry process must be available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

All populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, Veterans, families with children, youth, and survivors of domestic violence, must have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the system.

Regional Committees should take reasonable steps to ensure effective communication with individuals with disabilities, including providing information in appropriate accessible formats as needed (e.g., Braille, audio, large type, assistive listening devices, and sign language interpreters). Regional Committees should take reasonable steps to ensure the coordinated entry process can be accessed by persons with Limited English Proficiency (LEP).

Participants must be informed of the ability to file a nondiscrimination complaint. Participants may file a fair housing complaint:

- With HUD by calling 1-800-669-9777 or online using this link https://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/online-complaint.
- With the North Carolina Department of Administration using this link <https://files.nc.gov/ncdoa/documents/files/HousingDiscriminationComplaint.pdf>

NC Balance of State Continuum of Care Program Standards Street Outreach



OVERVIEW

The NC Balance of State Continuum of Care has developed these program standards to provide specific guidelines for how programs can operate to have the best chance of ending homelessness. These guidelines create consistency across the Balance of State, protect our clients by putting their needs first, and provide a baseline for holding all CoC programs to a specific standard of care.

The Department of Housing and Urban Development (HUD) requires every Continuum of Care to evaluate outcomes of projects funded under the Emergency Solutions Grants program and the Continuum of Care program and report to HUD (24 CFR 578.7(a)7). In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individual and families for housing and services.

In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and consistently follow written standards for providing CoC assistance. At a minimum, these standards must include:

- Policies and procedures for evaluating individuals' and families' eligibility and determining the process for prioritizing eligible households in street outreach, emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing programs (24 CFR 578.7(a)(9)).
- Program standards that meet HUD's requirements for street outreach to define policies and procedures for engagement, program enrollment, referral, and discharge standards as well as safeguards to meet needs for special populations such as victims of domestic violence, dating violence, sexual assault, and stalking.
- Policies and procedures for coordination among street outreach programs, emergency shelters, transitional housing programs, essential service providers, homelessness prevention programs, rapid re-housing programs, and permanent supportive housing programs.
- Definitions for participation in the CoC's Homeless Management Information System (or comparable database for domestic violence or victims' service programs).

The NC Balance of State Continuum of Care developed the following street outreach program standards to ensure:

- Program accountability to individuals and families experiencing unsheltered homelessness, specifically populations at greater risk or with the longest histories of homelessness
- Program compliance with the Department of Housing and Urban Development
- Service consistency within programs
- Adequate program staff competence and training, specific to the target population served

EXPECTATIONS

All program grantees using Department of Housing and Urban Development Emergency Solutions Grant funding must adhere to these performance standards and will be monitored by the NC Balance of State Continuum of Care to ensure compliance. The NC BoS CoC recommends that street outreach programs funded through other sources also follow these standards. These



performance standards attempt to provide a high standard of care that places community and client needs first. Based on best practices, this high standard of care is necessary to achieve our goal of ending homelessness in the NC BoS CoC.

STREET OUTREACH

Street outreach programs are designed to engage unsheltered people at non-traditional settings such as campsites, public parks, libraries, bus or train stations, exit or entrance ramps to roads and highways, abandoned buildings, or under bridges. Outreach workers may also engage people at local basic needs organizations such as feeding sites, soup kitchens, clothing centers, or other sites. Street outreach programs serve as the front door for unsheltered individuals to homeless and permanent housing services. Effective street outreach programs connect ignored or underserved people with emergency services, longer-term mental and physical health services, and permanent housing. Street outreach also helps to re-integrate unsheltered homeless individuals and families into the larger community.

Outreach programs should meet people where they are, both geographically and emotionally. This means meeting people in locations that are most convenient for them as well as developing trusting relationships with unsheltered people through active listening, persistence, consistency, and without judgement.

Because outreach happens in non-traditional settings with people who often have complex needs, outreach workers face challenges that require special skills to do their job well. Engaging unsheltered people on their turf means workers must be able to maintain their and their client's safety, have strong ethics and boundaries, and good coping skills after working under very difficult and stressful circumstances. Outreach workers must make frequent judgement calls about balancing safety and ethics with clients' needs.

Since street outreach programs work with a vulnerable population that often has little or no access to services, a main component of street outreach work is to ensure the survival of people living on the streets. Street outreach programs provide necessary supplies for living unsheltered and assist people to access emergency shelters, especially during very cold or hot times of the year.

Street outreach programs are more prevalent in urban centers than rural areas. Often, this discrepancy exists because of several factors, including access to funding, number of potential unsheltered individuals needing assistance, and difficulty covering large rural areas. However, rural or non-urban communities can and should operate street outreach programs to connect the most vulnerable members of the homeless population to necessary services and permanent housing. Street outreach in rural or non-urban areas will take more planning and more time to adequately engage the target population. Creating known locations lists that programs can visit and add to over time, regularly engaging community providers, including law enforcement and other city and county departments coming into contact with unsheltered people, and creatively including homeless and formerly homeless individuals to assist in engagement of this population are necessary in rural or non-urban areas to provide effective street outreach.



Street outreach programs should operate with a Housing First approach. Housing First programs believe that anyone can and should be housed and the barriers to permanent housing should be minimized. Housing First allows street outreach programs to move unsheltered individuals more quickly from places not meant for human habitation into permanent housing.

Every street outreach program should participate in the local community's coordinated assessment system. In the NC BoS CoC, each community utilizes the Prevention and Diversion screening tool to help divert people from homelessness and assess their needs for emergency services, and the Individual and Family VI-SPDAT Prescreen Tools to assess client service needs and set priorities for permanent housing. Housing programs use the Case Management Tool for more developed housing placement purposes and for intensive case management over time. Street outreach programs should administer the VI-SPDAT as soon as appropriate, eschewing the agreed upon 14-day waiting period, to quickly get clients onto the community's waiting list for permanent housing.

DEFINITIONS

Acuity: When using the VI-SPDAT prescreens, acuity means the presence of a presenting issue based on the prescreening score. Acuity on the prescreening tool is expressed as a number with the higher score representing more complex, co-occurring issues likely to impact overall stability in permanent housing. When using the Case Management Tool, acuity refers to the severity of the presenting issue and the ongoing goals in addressing these issues.

Case Management Tool: A standardized tool for case management to track outcomes in the coordinated assessment process. Housing programs administer this tool at program entry, housing entry, and every six months thereafter until program discharge. Upon discharge from the program, housing case managers administer the tool one final time 12 months later, when possible, to ensure the household continues to make progress.

Chronically Homeless: (1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) has been homeless and living as described in (i) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; (2) an individual who has been residing in an institutional care facility, including jail, substance abuse, or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) a family with an adult head of household (or if there is not adult in the family, a minor head of household) who meets all of the criteria in (1) or (2) of this definition, including a family whose composition had fluctuated while the head of homelessness has been homeless. (24 CFR 578.3)

Comparable Database: HUD-funded providers of housing and services (recipients of ESG and/or



CoC funding) who cannot enter information by law into HMIS (victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database comparable to HMIS. According to HUD, “a comparable database . . . collects client-level data over time and generates unduplicated aggregate reports based on the data.” The recipient or subrecipient of CoC and ESG funds may use a portion of those funds to establish and operate a comparable database that complies with HUD’s HMIS requirements. (24 CFR 578.57)

Coordinated Assessment: “A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The . . . system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool” (24 CFR 578.3). CoC’s have ultimate responsibility to implement coordinated assessment in their geographic area.

Developmental Disability: As defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002): (1) A severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major life activities: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; (v) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (2) an individual from birth to age 9, inclusive, who has a substantial developmental disability or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria in (1)(i) through (v) of the definition of “developmental disability” in this definition if the individual, without services or supports, has a high probability of meeting these criteria later in life. (24 CFR 578.3)

Disabling Condition: According to HUD: (1) a condition that: (i) is expected to be of indefinite duration; (ii) substantially impedes the individual’s ability to live independently; (iii) could be improved by providing more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or a developmental disability, as defined above; or the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from AIDS, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5)

Diversion: Diversion is a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion practices and programs help reduce the number of people becoming homeless and the demand for shelter beds.

Family: A family includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) a single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or (2) a group of persons residing together, and such group includes, but is not limited to: (i) a family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) an elderly family; (iii) a near-elderly family; (iv) a



disabled family; (v) a displaced family; and (vi) the remaining member of a tenant family. (24 CFR 5.403)

Homeless: *Category 1:* an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals); or (iii) an individual who exits an institution where he/she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

Category 2: an individual or family who will immediately lose their primary nighttime residence, provided that: (i) the primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) no subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing; or

Category 4: any individual or family who: (i) is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence; (ii) had no other residence; and (iii) lacks the resources or support networks (e.g. family, friends, and faith-based or other social networks) to obtain other permanent housing. (24 CFR 578.3)

Housing First: A national best practice model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment compliance, and service and/or income requirements. Programs offer supportive services to maximize housing stability to prevent returns to homelessness rather than meeting arbitrary benchmarks prior to permanent housing entry.¹⁰

Prevention and Diversion Screening Tool: A tool used to reduce entries into the homeless service system by determining a household's needs upon initial presentation to shelter or other emergency response organization. This screening tool gives programs a chance to divert households by assisting them to identify other permanent housing options and, if needed, providing access to mediation and financial assistance to remain in housing.

Rapid Re-housing: A national best practice model designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve long-term stability. Like Housing First, rapid rehousing assistance does not require adherence to preconditions such as employment, income, absence of criminal record, or sobriety. Financial assistance and housing stabilization services match the specific needs of the household. The core components of rapid rehousing are housing identification/relocation, short- and/or medium-term rental and other financial assistance, and case management and housing stabilization services. (24 CFR 576.2)

Transitional Housing: Temporary housing for participants who have signed a lease or occupancy agreement with the purpose to transition households experiencing homelessness into permanent housing within 24 months.

VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool): An evidence-

¹⁰ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf>



based tool used by all regions in the Balance of State to determine initial acuity and set prioritization and intervention for permanent housing placement.

PERFORMANCE STANDARDS

PERSONNEL

STANDARD: The program shall adequately staff services with qualified personnel to ensure quality of service delivery, effective program administration, and the safety of staff and program participants.

Benchmarks

- The organization selects employees and/or volunteers with adequate and appropriate knowledge, experience, and stability for working with unsheltered individuals and families.
- The organization provides time for all employees and/or volunteers to attend webinars and/or trainings on program requirements, compliance, and best practices.
- The organization trains all employees and/or volunteers on program policies and procedures, available local resources, and specific skill areas relevant to assisting clients in the program.
- All programs should use the Homeless Management Information System (HMIS) wherein all end users must abide by the NC HMIS User and Participation Agreements, including adherence to the strict privacy and confidentiality policies.
- Staff supervisors of casework, counseling and/or case management services have, at a minimum, a bachelor's degree in a human service-related field and/or experience working with unsheltered individuals and families.
- All program staff have written job descriptions that address tasks staff must perform and the minimum qualifications for the position.
- The organization will train program staff on general topics such as self-care, teamwork, boundaries and ethics, and personal safety. It will also train staff on specific skills necessary to effectively connect with unsheltered individuals, including, but not limited to, relationship-building, motivational interviewing, cultural competence, effective referrals and linkages, basic medical and mental health care, and conflict de-escalation.
- The organization should share and train all program staff on the NC Balance of State CoC Street Outreach Written Standards.

OUTREACH AND ENGAGEMENT

STANDARD: Programs will locate, identify, and build relationships with unsheltered people experiencing homelessness and engage them for the purpose of providing immediate support, intervention, and connections with homeless assistance programs, mainstream social services, and permanent housing programs.

Benchmarks

- All participants must meet the following program eligibility requirements for street outreach programs:
 - Unsheltered homeless, living in places not meant for human habitation such as campsites, abandoned buildings, bus or train stations, in cars, or under bridges (see definitions listed above for Category 1 (i)).



- All ESG recipients must use the standard order of priority for documenting evidence to determine unsheltered homeless status. Grantees must document in the client file that the agency attempted to obtain the documentation in the preferred order. The order should be as follows:
 - Third-party documentation (including HMIS)
 - Intake worker observations through outreach and visual assessment
 - Self-certification of the person receiving assistance
- Programs should engage individuals, make an initial assessment of needs, and determine unsheltered homeless status. During outreach, if programs determine that an individual does not meet the definition of unsheltered homelessness, they should still connect any literally homeless person needing assistance to the local coordinated assessment system to access needed services, but not enroll them for expanded services in the street outreach program.
- Programs can only turn away unsheltered individuals from program entry for the following reasons:
 - The individual does not meet the unsheltered homeless definition
 - The safety of staff is at imminent risk
- Programs cannot disqualify an individual or family from entry because of employment status or lack of income.
- Programs cannot disqualify an individual or family because of evictions or poor rental history.
- Programs may make services available and encourage engaged individuals to participate in higher level services but cannot make service usage a requirement. Street outreach programs should continue to outreach and engage unsheltered individuals on a regular basis, offering them higher level services and ensuring basic needs are met.
- Programs will maintain releases of information, case notes, and all pertinent demographic and identifying data in HMIS as allowable by program type. Paper files should be maintained in a locked cabinet behind a locked door with access strictly reserved for case workers and administrators who need said information.
- Programs may deny entry or terminate services for program specific violations relating to safety and security of program staff and participants.

STREET OUTREACH

STANDARD: Street outreach programs will provide assertive outreach and engagement to unsheltered individuals living in places not meant for human habitation, and assist them in accessing emergency shelter, physical and behavioral health services, income supports, and permanent housing.

Benchmarks

- Street outreach programs will assertively outreach and engage unsheltered individuals where they are, seeking them in campsites, under bridges, near entrance and exit ramps to roads and highways, in abandoned buildings, living in bus or train stations, or other places not meant for human habitation.
- Street outreach programs will collaborate with local service or basic needs providers and organizations where unsheltered individuals seek basic services such as food pantries, crisis centers, community centers, day shelters, and others, setting up regularly scheduled times to outreach and engage unsheltered individuals in these locations.



- Street outreach programs should provide outreach and engagement, crisis intervention counseling, case management, emergency and permanent housing planning, employment and other income assistance, and life skills training. Program staff should help unsheltered individuals connect to physical and mental health services, substance abuse treatment, transportation, services for special populations (i.e. developmental disabilities, HIV/AIDS), and other mainstream services, including public benefits such as Social Security Disability, Medicaid/Medicare, Food Stamps, TANF. Street outreach programs should not deny or terminate services to individuals unwilling or unable to obtain higher level services or follow a basic case management plan.
- Street outreach programs must actively participate in their community's coordinated assessment system. Program staff should assess unsheltered individuals with the VI-SPDAT and advocate for permanent housing for these individuals at the local case conferencing meeting.
- Street outreach programs shall not charge money for any housing or supportive service provided.
- Street outreach programs must work to link their clients to permanent housing programs, such as rapid re-housing and permanent supportive housing, in the community.

CASE MANAGEMENT SERVICES

STANDARD: Street outreach programs shall provide access to case management services by trained staff to any unsheltered individual, matching his/her needs and desire.

Benchmarks (Standard available services)

- Street outreach staff provide regular and consistent case management to program participants based on the individual's specific needs and the level at which the participant desires. Case management includes:
 - Building trusting, lasting relationship with unsheltered individuals.
 - Providing access to basic needs, including identification, health care services, public benefit enrollment, food, clothing, and hygiene items.
 - Assessing, planning, coordinating, implementing, and evaluating the services delivered to the participant. Program staff should engage participants in an individualized housing and services plan. Participants do not need to access additional services to be referred to permanent housing providers.
 - Helping clients to create strong support networks and participate in the community, as they desire.
 - Encouraging unsheltered individuals to seek emergency shelter and advocating with local shelter providers to accept and work with the individual. The program can and should continue to work with an unsheltered participant who accesses emergency shelter to serve as an advocate and liaison to higher level services such as permanent housing.
 - Creating a path for clients to permanent housing through providing rapid re-housing or permanent supportive housing or a connection to another community program that provides these services. Program staff should conduct the VI-SPDAT as quickly as possible and ensure participants information is added to the community's waiting list.



- Street outreach staff or other programs connected to the outreach program through a formal or informal relationship will assist residents in accessing cash and non-cash income through employment, mainstream benefits, childcare assistance, health insurance, and others.

Benchmarks (Optional but recommended services, often from other providers)

- Representative payee services.
- Basic life skills, including consumer education, bill paying/budgeting/financial management, transportation, and obtaining vital documents (social security cards, birth certificates, school records).
- Education services such as GED preparation, post-secondary training, and vocational education.
- Employment services, including career counseling, job preparation, resume-building, dress and maintenance.
- Behavioral health services such as relapse prevention, crisis intervention, medication monitoring and/or dispensing, outpatient therapy and treatment.
- Physical health services such as routine physicals, health assessments, and family planning.
- Legal services related to civil (rent arrears, family law, uncollected benefits) and criminal matters (warrants, minor infractions).

TERMINATION

STANDARD: Termination should be limited to only the most severe cases. Programs will exercise sound judgment and examine all extenuating circumstances when determining if violations warrant program termination (24 CFR 576.402). The NC BoS CoC recommends programs work with other community service providers to develop a board to hear client grievances.

Benchmarks

- In general, the program may terminate assistance in accordance with a formal process established by the program that recognizes the rights of individuals and families affected. The program is responsible for providing evidence that it considered extenuating circumstances and made significant attempts to help the client continue in the program. Programs should have a formal, established grievance process in its policies and procedures for participants who feel the street outreach program wrongly terminated assistance.
- Programs should only terminate assistance when a participant has presented a terminal risk to staff or other clients. If a barred client presents him/herself at a later date, programs should review the case to determine if the debarment can be removed to give the participant a chance to receive further assistance.

CLIENT AND PROGRAM FILES

STANDARD: Street outreach programs will keep all client files up-to-date and confidential to ensure effective delivery and tracking of services.

Benchmarks

- Client and program files should, at a minimum, contain all information and forms required by HUD at 24 CFR 576.500 and the state ESG office, service plans, case notes, referral lists, and service activity logs including services provided directly by the street outreach program and indirectly by other community service providers. ESG requires:



- Documentation of unsheltered homeless status (see above for the priority of types of documentation)
 - Determination of ineligibility, if applicable, which shows the reason for this determination
 - Program participant records
 - Documentation of using the community's coordinated assessment system
 - Services and assistance provided
 - Expenditures and match
 - Conflict of interest/code of conduct policies
 - Homeless participation requirement
 - Faith-based activity requirement, if applicable
 - Other Federal requirements, if applicable
 - Confidentiality procedures
- All client information should be entered into the NC HMIS in accordance with data quality, timeliness, and additional requirements found in the agency and user participation agreements. At a minimum, programs must record the date the participant enters and exits the program, enter HUD required data elements, and update the participant's information as changes occur.
 - Programs must maintain the security and privacy of written client files and shall not disclose any client-level information without written permission of the participant as appropriate, except to program staff and other agencies as required by law. Participants must give informed consent to release any client identifying data to be utilized for research, teaching, and public interpretation. All programs must have a consent for release of information form for participants to use to indicate consent in sharing information with other parties.
 - All records pertaining to ESG funds must be retained for the greater of 5 years or the participant records must be retained for 5 years after the expenditure of all funds from the grant under which the program participant was served. Agencies may substitute original written files with microfilm, photocopies, or similar methods.

EVALUATION AND PLANNING

STANDARD: Street outreach programs will conduct ongoing planning and evaluation to ensure programs continue to meet community needs for individuals and families experiencing unsheltered homelessness.

Benchmarks

- Agencies maintain written goals and objectives for their services to meet outcomes required by ESG.
- Programs review case files of clients to determine if existing services meet their needs. As appropriate, programs revise goals, objectives, and activities based on their evaluation.
- Programs conduct, at a minimum, an annual evaluation of their goals, objectives, and activities, adjusting the program as needed to meet the needs of the community.
- Programs regularly review project performance data in HMIS to ensure reliability of data. Programs should review this information, at a minimum, quarterly.



APPENDIX 5: SIGNIFICANT CHANGE POLICY



North Carolina Balance of State Continuum of Care

bos@ncceh.org

919.755.4393

www.ncceh.org/BoS

NC Balance of State Continuum of Care Grant Significant Change Policy

This policy applies to all recipients of HUD Continuum of Care (CoC) Program funding, including legacy Shelter Plus Care (S+C) funding.

Steering Committee Role

The NC Balance of State CoC Steering Committee is responsible for approving CoC funding applications on an annual basis. CoC grants are recommended by the Project Review Committee and approved by the Steering Committee based on the content of the initial project application.

On occasion, a significant change may be necessary to continue to effectively implement the grant. Because significant changes represent a departure from the initial, approved application and substantially affect project implementation, these changes require approval from the Steering Committee. After the Steering Committee approves the significant change, the grant recipient may then proceed to request the change from the HUD Field Office.

Significant Changes

Significant changes that require Steering Committee approval include:

- Change of recipient (grant transfer) or change of subrecipient
- Change of project site
- Addition or elimination of eligible costs approved for a project
- Shift of more than 10% of funds from one approved eligible cost category to another
- Permanent change in subpopulation served by any one project under the grant
- Permanent reduction in the total number of units funded under the grant
- Permanent closure of the project funded by the grant
- Voluntary relinquishment of grant funding

Noncompliance with Policy

If a recipient agency requests a grant amendment from HUD or otherwise implements a significant change without first receiving approval from the NC BoS CoC, the Steering Committee has the discretion to determine the consequences, which may include reducing or eliminating funding in the next CoC competition.

