06. CoCs Governance Charter

Governance Charter of the Cuyahoga County Continuum of Care

Governance Charter Purpose

This Charter sets forth the guiding principles of membership and participation in the Cuyahoga County Continuum of Care (CoC) and the provisions for Continuum governance through the Office of Homeless Services (OHS) Advisory Board, and key policies and procedures as defined in the OHS Advisory Board Bylaws, attached to this Charter.

- The governing body for the Cuyahoga County Continuum of Care (CoC) is the OHS Advisory Board. This charter and the Bylaws together detail the roles and responsibilities of the CoC and the OHS Advisory Board, as well as the rules and policies governing meetings, subcommittees, and decision making.
- The OHS Advisory Board and the CoC membership will review this Charter annually to ensure it remains consistent with HUD's CoC Program Requirements as well as CoC objectives and responsibilities.
- The OHS Advisory Board will have the power to adopt, amend, or repeal provisions of this Governance Charter by a majority vote of the Advisory Board present at any meeting where the proposed action has been described in the notice of the meeting. Such amendments will then be reviewed by the full CoC membership annually.

A. Terms and Definitions

CoC Program Grantee (Recipient): The CoC Program Grantee is the "recipient" as used by HUD and means an applicant that signs a grant agreement with HUD.

Collaborative applicant: The eligible applicant that has been designated by the OHS Advisory Board to respond to the Notice of Fund Availability (NOFA) and to apply for Continuum of Care planning funds on behalf of the Continuum. Section E. of this Charter designates the Office of Homeless Services as the Collaborative Applicant for the Cuyahoga County Continuum of Care.

Continuum of Care Membership: The agencies and individuals who are stakeholders in achieving the Continuum of Care goals and objectives to reduce and end homelessness for all populations in the community. **CoC Membership includes anyone who is interested in reducing and ending homelessness in the geographic area of the CoC, and who attends the most recent General CoC Membership meeting.**

Homeless Management Information System (HMIS): The information system designated by the CoC to comply with the HMIS requirements prescribed by HUD. The Cuyahoga County Advisory Board CoC selected Bowman Systems, LLC, ServicePoint Software in 2003, for the CoC's HMIS provider. This is noted in Section E. of the Charter.

HMIS Lead: The entity designated by the OHS Advisory Board in accordance with this part, to operate the CoC's HMIS on its behalf. Section E. of this Charter designates the Office of Homeless Services as the HMIS Lead for the CoC.

Office of Homeless Services Advisory Board: The Office of Homeless Services (OHS) Advisory Board is the governing body of the CoC. It was originally established through legislative action by the City of Cleveland and Cuyahoga County in 1992. It is the group of persons elected according to the Bylaws of the CoC, to carry out the goals and objectives of the HEARTH Act on behalf of the Continuum of Care and in accordance with the CoC Charter and Bylaws.

Office of Homeless Services: The Office of Homeless Services was established through legislative action by the City of Cleveland and Cuyahoga County in 1992. It is currently a department within the County's Health & Human Services Department. Organizational funding for the OHS is provided 100% by the Health & Human Services Levy of Cuyahoga County. The OHS staff and operational procedures are dictated by the Charter of Cuyahoga County. The OHS has been designated by the OHS Advisory Board as the Collaborative Applicant on behalf of the CoC.

B. *CoC Purpose/Membership*

I. The purpose of the CoC is to:

- promote communitywide commitment to the goals of ending **all** homelessness through strategies aligned with Opening Doors, the Federal Strategic Plan To Prevent and End Homelessness, adopted by the Inter-Agency Council on Homelessness and amended in FY2015. The goals are:
  1. Prevent and end homelessness among Veterans in 2015;
  2. Finish the job of ending chronic homelessness in 2017;
  3. Prevent and end homelessness for families, youth, and children in 2020;
  4. Set a path to end all types of homelessness.

II. The membership of the Continuum of Care is defined as anyone who is interested in ending homelessness and who attends and participates in the most recent CoC General Membership Meeting.

- Information about the General Membership Meeting is made available through e mail list serve and on the Office of Homeless Services' website.
- There will be two General Membership Meetings annually, the dates to be determined by the OHS Advisory Board.

C. *The Office of Homeless Services Advisory Board Responsibilities*

1. Hold meetings of the full membership, with published agendas, at least two times a year;
2. Make a public invitation available for new members to join the CoC within the geographic area at least annually;
3. Adopt and follow a written process to select Board members to act on behalf of the CoC. The process must be reviewed, updated, and approved by the larger CoC membership at least once every 5 years;
4. Appoint committees, subcommittees, and/or workgroups;
5. Assure that all Advisory Board members adhere to the Conflict of Interest rules as described in detail in the OHS Advisory Board Bylaws;
6. Designate the Collaborative Applicant, a single HMIS for the geographic area, and the HMIS Lead. The OHS Advisory Board has designated the Office of Homeless Services (OHS) as the Collaborative Applicant and the HMIS Lead.

7. The OHS Advisory Board gives authority to the OHS to conduct the following activities, to be developed and presented to the OHS Advisory Board for formal votes as required by law:
    a) Consult with recipients and sub-recipients of CoC funding to establish performance targets appropriate for population and program type; monitor recipient and sub-recipient performance, evaluate outcomes, and take action against poor performers;
    b) Evaluate outcomes of projects funded under the City of Cleveland/Cuyahoga County Emergency Solutions Grants program (hereinafter referred to as "ESG") and the CoC program, and report to HUD;
    c) Establish and operate a centralized and coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services;
    d) Develop written standards for providing Emergency Solutions Grant (ESG) and Continuum of Care (CoC) assistance;
    e) Develop a plan that includes coordinating the implementation of a housing and service system within its geographic area that meets the needs of the homeless individuals (including unaccompanied youth) and families;
    f) Plan for and conduct, at least biennially, a **point-in-time count** of homeless persons within the geographic area that meets the HUD requirements:
    g) Provide information required to complete the Consolidated Plan(s) within the CoC's geographic area;
    h) Consult with state and local government ESG program recipients for allocating ESG funds and reporting on and evaluating the performance of ESG recipients and sub-recipients.
    i) Design, develop, and implement an annual project review and selection process that is fair and transparent;
    j) Establish and implement an application process for the annual NOFA process.

Additional detail on the rules and requirements governing the OHS Advisory Board are discussed in the OHS Advisory Board Bylaws attached to the Charter.

D. *Limited Authority*

Neither the CoC membership nor the OHS Advisory Board is a formal organization. As such:

- Neither has, and can have, assets or liabilities;
- Neither can indemnify member or participant action; and
- No member of the CoC, the OHS Advisory Board, or its committees/workgroups, may contract, incur debt, or otherwise create an enforceable obligation for the CoC, the OHS Advisory Board, or its committees.
- Only the OHS Advisory Board may designate an individual or entity to speak for the CoC or its components.
- With the exception of removal policies in this Charter, any grievance related to the CoC will follow HUD policies and contracts.

E. *Collaborative Applicant, HMIS, and HMIS Lead*

As required, the Charter identifies the following:

- CoC Collaborative Applicant: Cuyahoga County Office of Homeless Services

- HMIS provider and Software: Bowman Systems, LLC; ServicePoint
- HMIS Lead: Cuyahoga County Office of Homeless Services

ATTACHMENTS TO THE CHARTER:

1. ***Office of Homeless Services Advisory Board Bylaws***
2. ***HMIS Policy and Procedures Manual***
   As required by the HEARTH Act, the CoC HMIS Policy and Procedures Manual is attached to the Charter document as ATTACHMENT II.

3. ***Written Standards for Order of Priority***

4. ***Coordinated Entry Policies and Procedures – under development***

5. ***Rapid Re-Housing – Standards for Assistance – under development***

ATTACHMENT I

Office of Homeless Services Advisory Board Bylaws

BYLAWS OF THE CLEVELAND/CUYAHOGA COUNTY OFFICE OF HOMELESS SERVICES ADVISORY BOARD

ARTICLE I
LEGAL STATUS AND PURPOSE

The creation of the Cleveland/Cuyahoga County Office of Homeless Services (OHS) Advisory Board was provided by an agreement between the City of Cleveland and the Board of County Commissioners on May 26, 1992 pursuant to the Ohio Revised Code Section 307.15. The OHS Advisory Board shall be the governing body of the Cuyahoga County Continuum of Care (CoC) in accordance with the Governance Charter of the CoC.

ARTICLE II
MISSION AND GOALS

The goals of the Advisory Board as stated in the Board's Mission and Goals Statement are consistent with the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act and the priorities of the U.S. Interagency Council on Homelessness (USICH) as follows:

1. To assist the Office of Homeless Services (OHS) to reduce and end homelessness through advocacy, policy review, priority setting, coordination, and the alignment of community resources.

2. Facilitate interagency and intergovernmental cooperation, and promote private sector collaboration and participation.

3. Clarify and prioritize the goals of the Cleveland/Cuyahoga County Continuum of Care.

4. Identify and review local, state, and federal public policy issues impacting individuals and families experiencing homelessness.

5. Develop financial priorities for the distribution of public funds, and influence the distribution of private funds.

6. Establish criteria to monitor and evaluate delivery of services.

7. Develop avenues to communicate concerns regarding policy issues.

ARTICLE III
MEMBERSHIP

Section I: Representation. The Advisory Board shall be broadly based with representation from all sectors of the community, in compliance with the HEARTH Act, 24 CFR Subpart B, 578.5 -7. The HEARTH Act requires that the governing body of the CoC be comprised of "relevant" organizations and provides examples of what is considered "relevant organizations". This list includes, but is not limited to, the following: nonprofit homeless assistance 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, and organizations that serve veterans. The only required category of representation is a homeless or formerly homeless person.

Section II: Board Composition. The Advisory Board shall be composed of a minimum of 25 and a maximum of 27 members. The Advisory Board membership shall consist of 20-22 standing seats and 5 at-large seats.

STANDING/DESIGNATED SEATS

The standing/designated seats will be:

a. Two Cuyahoga County representatives to be recommended by the County Executive from the following County Departments and Offices: Children and Family Services, Employment and Family Services, Development, Health, Office of Re-entry, Senior and Adult Services, and Law Enforcement.
b. One representative of Cuyahoga County Council who is either a County Council member or staff person.
c. Two City of Cleveland representatives to be recommended by the Mayor from the following City Departments: Community Development, Health, Office on Aging, Public Safety/Law Enforcement, and Minority Affairs.
d. One representative of Cleveland City Council who is either a City Council member or a staff person.
e. One representative from Cuyahoga Metropolitan Housing Authority.
f. One representative from the Veterans Administration.
g. One representative from the Alcohol Drug Addiction and Mental Health Services Board
h. One representative from the Cleveland Metropolitan School District Basic Education for Homeless Children and Youth Act activities.
i. One representative from Care Alliance Health Center, the federally-funded Health Care for the Homeless grantee (HRSA 330 (h))
j. One representative from the Northeast Ohio Coalition for the Homeless.
k. Two to Four persons who are presently homeless or have previously experienced homelessness.
l. Six persons selected by providers who receive any CoC targeted funding.

AT-LARGE SEATS

Five at-large seats will be filled by persons who have skills, expertise or influence that can help achieve the goals of the CoC, and are not staff members of a recipient of CoC funds, from the following examples but not limited to:

a. Housing Agency
b. Behavioral Health Care
c. Non-profit Housing Developer
d. Community Development Corporation
e. Health Care Provider
f. Faith Based Group
g. Advocacy Group
h. Philanthropy
i. Youth Serving Agency
j. Employment Agency
k. HIV/AIDS Provider
l. Senior Services
m. Development/Cognitive Disability Agency
n. Regional Transit Authority
o. Victim Service Provider
p. Legal
q. Local Governmental Units
r. Higher Education
s. Law Enforcement
t. Reentry

Section III: Terms of Service. All Advisory Board members shall be elected for a board term of three (3) years. Advisory Board members may be elected to any number of additional three (3) year terms. For the first Advisory Board to be elected upon approval of these Revised By-Laws there will be a staggering of terms with one-third (1/3) of the board members to be elected to a two year term, one-third (1/3) elected to a three year term, and one-third (1/3) elected to a four year term. All subsequent terms shall be three (3) years.

- Standing/designated members shall be recommended by designating authority in consultation with the Governance Committee for election to the board.
- All At-large members shall be recommended by the Governance Committee for election to the board.

Section IV: Proxies. A member of the Advisory Board may designate one person as a proxy to represent him/her/ the seat, to attend and vote at Advisory Board meetings, by notifying the Co-Chairs in writing prior to the meeting(s) that the Proxy will attend. If a proxy is designated, the same person should be the proxy representative for any future Advisory Board meetings, when necessary.

Section V: Vacancies. Vacancies will be filled as follows:

- Designated members-
  - The Designating Authority will be responsible for designating another representative to be elected to fill a vacant seat, whether at the end of a term or during a term;
- Elected members –
  - Any elected member unable to fulfill a term may recommend another person from their own membership category to be elected to fill the remaining time of the term. At the end of the term, a member would be identified through the nomination/election process described in Article IV, Section II.

ARTICLE IV
SELECTION AND REMOVAL OF MEMBERS

Section I: Designation Process. No less than eight weeks prior to the month in which a new Advisory Board term is to begin, designating authorities will be contacted in writing by Governance committee to meet and determine the designees recommendation to the Advisory Board. Designating authorities in consultation with the Governance Committee may either recommend the current designee or recommend another designee. Appointees will be contacted to determine their willingness and ability to serve. If willing and able, the appointment will be ratified at the beginning of the term of office. If not willing or able, the appointing authority will be contacted and asked to select a new appointee.

Section II: Nomination and Election Process for At-Large seats. No less than eight weeks prior to the month in which elected terms begin, the Governance Committee, shall determine whether current at-large Advisory Board members will be recommended for a subsequent term or will circulate a "Call for Nominations" to organizations and parties deemed appropriate. The "Call for Nominations" will:

- set forth the criteria for nomination to the Advisory Board,
- set a deadline for the receipt of said nominations.

Advisory Board members may recommend nominees to the Governance Committee.

The Governance committee will:

- develop a screening process

- interview selected candidates to evaluate their willingness and ability to serve;
- prepare brief synopses of the candidates' qualifications for the Board; and
- recommend a slate of candidates to the Board for election.

The Governance Committee will provide in writing the full list of names of those who applied for Advisory Board membership, as well as a slate of recommended candidates no later than two weeks prior to the next regularly scheduled meeting at which the vote for electing members will be taken.

Section III: Removal. Failure to attend three (3) consecutive Advisory Board meetings without excused absences may be grounds for removal. If the member is a designee to the Board, the designating authority and the designee will be notified in writing after two (2) unexcused absences that three (3) consecutive unexcused absences is grounds for removal. If the member is an at-large member of the Board, the member will be notified in writing after two (2) unexcused absences that missing three (3) meetings constitutes grounds for removal.

At the next regularly scheduled meeting, the Advisory Board will take action that may include voting to remove. If removed, the member, and appointing authority if applicable, will be notified. If either an at-large or designated member must be replaced the process will follow the appropriate procedures described in Article II Section V above.

ARTICLE V
OFFICERS AND COMMITTEES

Section I: Officers. The Advisory Board shall elect two co-chairpersons from among its members. The Advisory Board will annually elect one of the co-chairpersons for a two year term. A Co-Chair may serve for no more than two consecutive two year terms. To insure staggered terms, for the initial election of co-chairs, one will be elected for a one year term and one for a two year term, with subsequent terms being two years.

Section II: Responsibilities of Officers. The Co- Chairs will serve as leaders of the Office of Homeless Services Advisory Board and at least one Co-Chair will represent the Board in all public venues. The Co-Chairs will convene Advisory Board meetings for the purpose of fulfilling the Board Responsibilities stated in the Cuyahoga County Continuum of Care Charter Section C.

Section III: Committees.
The Advisory Board shall have four standing committees and additional ad hoc committees and work groups as deemed necessary. The four standing committees with respective roles are as follows:

1) Executive Committee
2) Emergency Solutions Grant (ESG) Committee
3) Review & Ranking Committee
4) Governance Committee

a) The Executive Committee shall be comprised of the co-chairs of the Advisory Board and the co-chair(s) of the ESG Committee, the co-chair(s) of the Governance Committee and the co-chair(s) of the Review & Ranking Committee.

The role of the Executive Committee is to:

- serve in an advisory capacity to the Office of Homeless Services staff between Advisory Board meetings,

- identify issues for deliberation by the Board as a whole,
- vote on matters that require immediate resolution between regularly scheduled Advisory Board meetings;
- Determine bi-monthly meeting and special meeting agendas

b) The ESG Committee shall be comprised of Advisory Board members and general CoC members. The Committee co-chairs, at least one of whom must be a Board member and the voting members of the committee will be appointed by the Advisory Board Co-Chairs.

The **role** of the Committee is to
- Establish ongoing CoC oversight and input for ESG Program implementation
- Review ESG best practices and support the implementation of the same,;
- Review policies and standards and submit as necessary proposed changes to the Advisory Board
- Help evaluate program effectiveness and report program outcomes to the Advisory Board.

c) The Review & Ranking Committee shall be comprised of Advisory Board members and other CoC members who are free of conflicts of interests related to the work of the Committee. The Committee co-chairs, at least one of whom is an Advisory Board member and the voting members of the committee will be recommended by the OHS staff and voted in by the Advisory Board.

The role of the Review and Ranking Committee is to:
- Develop a transparent, objective and fair project review process for the HUD NOFA process;
- Submit the proposed process to the Advisory Board for approval;
- Review renewal, new, and Bonus project applications for the annual NOFA process
- Develop and submit to the Advisory Board, recommendations about project acceptance or rejection, reallocations, and ranking for the NOFA application.

d) The Governance Committee shall be comprised of members of the Advisory Board who are not up for re-election. The Committee co-chairs will be appointed by the Advisory Board Co-Chairs.

The role of the Committee is to:
- Assure there is sufficient and appropriate Advisory Board membership
- Assure Advisory Board and the CoC compliance with Governance requirements
- Complete the work of nominations to the Advisory Board as defined in Article IV, Section II above.

e) Additional Committees: The Board may establish additional committees/work groups for specific purposes, chaired by a member of the Advisory Board and open to general CoC membership. The membership, role, and specific tasks of these work groups/committees will be defined by the Advisory Board and included in the Advisory Board Minutes.

Section IV: General Committee Responsibilities.
All committees are responsible for the following:
- Recruiting members

- Acting as a conduit for information sharing between the Advisory Board and CoC membership
- Establishing procedures as directed by the Advisory Board
- Recording minutes/attendance and providing them for publication
- Ensuring transparency of meetings and processes

ARTICLE VI
MEETINGS

Section I: Frequency of Meetings. The Advisory Board shall have a minimum of six meetings in a calendar year, with "Special" meetings on an as-needed basis.

Section II: General CoC Membership Meetings. The Advisory Board will assure that a minimum of two Advisory Board meetings annually meet the requirements to be considered as a CoC Membership meeting as required by the HEARTH Act.

Section III: Notice of Meetings. The staff of the OHS shall provide email notification of all CoC Membership, Advisory Board, ESG, Governance, and Executive Committee meetings, through distribution via the OHS email list serve. In addition, the CoC Membership Meetings Calendar will be posted on the OHS website, http://ohs.cuyahogacounty.us by January 3rd of each year. The location and time of the meetings will be included on the OHS website. Notice of any "Special" meetings shall be distributed at least seven (7) days prior to the meeting and in the same manner as provided herein for all meetings.

Section IV: Quorum. The presence of a majority of the Advisory Board members shall constitute a quorum. The Board shall conduct business only if a quorum is present.

Section V: Open Meetings. The Advisory Board Meetings are open to the CoC members and non CoC members.

Section VI: Action without a Meeting. Any action that may be taken at any meeting of the Advisory Board may be taken without a meeting if that action is approved in writing (e.g. letter, email) by a majority of all Advisory Board members who would be entitled to vote at a meeting held for such a purpose. The outcome of the Vote will be communicated to all Advisory Board and CoC Members through email and web posting.

Section VII: Conflict of Interest:

- A representative having a conflict of interest or a conflict of responsibility on any matter shall refrain from voting on such matter. Members of the OHS Advisory Board will sign a Conflict of Interest policy statement annually.
- No member of the Continuum will participate in the review, ranking, selection, or award of any grant funds in which they have a financial or oversight interest; or in which any member of their immediate family (such as parent, sibling, child, or person with whom they cohabit) has a financial oversight or interest.
- Members of the CoC will disclose potential conflicts of interest that they may have regarding matters that come before it in full session at the Advisory Board or in a work group.

ARTICLE VII

RULES OF ORDER

Section I: Whenever not in conflict with these Bylaws the deliberations of the Advisory Board shall be governed by Revised Roberts Rule of Order.

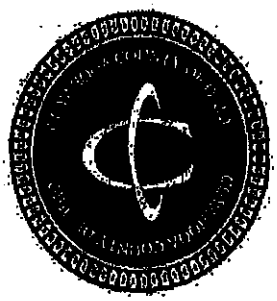
ARTICLE VIII
AMENDMENTS

Section I: The Bylaws will be reviewed at a minimum, every 5 years. The Bylaws may be amended, altered, or repealed by majority vote of the Advisory Board at a meeting of which a quorum is present, provided written notice of the proposed action has been given in the notice of the meeting.

ATTACHMENT II

HMIS Policies and Procedures Manual

Cleveland/Cuyahoga County Continuum of Care
Homeless Management
Information System



Policies & Procedures Manual

Office of Homeless Services
310 W. Lakeside Ave, Suite 595
Cleveland, Ohio 44113
Phone: (216) 420-6744
Ohio Relay Service (TTY): 1-800-750-0750
Fax: (216) 698-6604

Cleveland/Cuyahoga County Continuum of Care
Homeless Management Information System

Overview:

In 2001, Congress established a national goal and directive for HUD that all communities receiving HUD homeless program funding collect an array of data, including unduplicated counts of homeless, the use of services and the effectiveness of local assistance systems. In order to achieve this objective, HUD mandated that all communities develop a Homeless Management Information System (HMIS).

Beginning with the 2003 Continuum of Care (CoC) and Emergency Shelter Grants (ESG), the U.S. Department of Housing and Urban Development (HUD) required all grantees and sub-grantees to participate in their local HMIS. This policy is consistent with the Congressional Direction for communities to provide data to HUD on the extent and nature of homelessness and the effectiveness of its service delivery system in preventing and ending homelessness.

Mandated Participation
Projects authorized under HUD's McKinney-Vento Act as amended by the HEARTH Act must meet the minimum participation standards as outlined in this Policies and Procedures Manual.

Voluntary Participation
The Cleveland/Cuyahoga County Continuum of Care (CoC) strongly encourages homeless service providers to participate in the local HMIS. The HMIS lead agency works regularly with non-funded providers to communicate the benefits of HMIS and encourage participation.

The HMIS and its operating policies and procedures are structured to comply with the most recent *HUD Data and Technical Standards for HMIS.*

What is a Homeless Management Information System?

A Homeless Management Information System (HMIS) is a locally administered electronic data collection tool designed to capture client-level information over time on the characteristics, service needs, and service utilization of men, women, and children experiencing homelessness.

The HMIS Lead Agency, Cleveland/Cuyahoga County Office of Homeless Services (OHS), holds the contract with Bowman Systems for the use of an HMIS application known as ServicePoint. Under this agreement, OHS is the licensed administrator of ServicePoint which is managed by the System Administrator. The HMIS System Administrator ensures that the system is available to agency partners and providers within the Cleveland/Cuyahoga County Continuum of Care.

HMIS Solution:

Cuyahoga County has adopted the use of *ServicePoint* (from Bowman Systems) as its HMIS software solution. *ServicePoint* is a web-based application that requires no local software installation. It provides automatic reports to meet HUD reporting requirements and offers flexibility so that local agencies can customize its use for local needs. This platform was selected by a group of representatives of the Local Continuum of Care in 2002, following a highly participatory process of analysis of system needs and comparative examination of several top-rated software platforms.

The Homeless Management Information System (HMIS) project is administered by the Cleveland/Cuyahoga County Office of Homeless Services. The project utilizes the Internet-based technology to assist homeless service organizations across Cuyahoga County to capture information about the clients that they serve.

Potential benefits for agency and Program managers:

When aggregated, information can be used to garner a more complete understanding of clients' needs and outcomes, and then used to advocate for additional resources, complete grant applications, conduct evaluations of project services, and report to funders such as HUD. The software has the capability to generate the revised HUD Annual Progress Report (APR).

Potential benefits for homeless men, women, and children and case managers:

Directors, program managers, employees, and case managers can use the software as they assess their clients' needs to inform clients about services offered on site or available through referral. Employees and clients can use on-line resource information to learn about resources that help clients find and keep permanent housing or meet other goals clients have for themselves. Service coordination has been improved with the implementation of Coordinated Intake and Assessment and the sharing of information among HMIS Participating Agencies (with written consent) who are serving the same clients.

Potential benefits for community-wide Continuums of Care and policy makers:

Involvement in HMIS provides the capacity to projects within a Continuum to generate automated HUD APRs and to utilize the aggregate data to inform policy decisions aimed at preventing and reducing the number of persons experiencing homelessness at the county level.

Vision for HMIS

HMIS within the Cleveland/Cuyahoga County Continuum of Care continues to develop. The goals of our HMIS system demonstrate our united effort and dedication towards providing targeted services in order to reduce the number of newly homeless, reduce the length of stay for those who are homeless and reduce the number returning to shelter. We strive to provide the following:

- Coordinated case management across agencies, programs, projects and services
- Comprehensive information on clients served through a shared system
- Coordinated bed management
- An effective tool for tracking referrals and outcomes consistent with local planning and the Federal Plan to End Homelessness
- Customized assessments and reports which allow us to
    - Identify needs, resources and gaps through the use of data
    - Enhance strategic planning efforts
    - Continue to inform public policy regarding the nature and extent of homelessness in Cuyahoga County
    - Work with other local/state/federal entities to conduct cross-system analysis

This document provides the policies, procedures, guidelines, and standards that govern operations, as well as roles and responsibilities for OHS Staff and Participating Agency staff.

Governing Principles

- **Access to ServicePoint**

Each agency will designate specific staff as HMIS End Users. Each User will be issued one personal user license: **login ID** and **password** for access to the database. Each agency will also determine the user access level for each of its licensed Users. Licenses and access to the database will be cancelled immediately for any User that terminates employment. The Agency Administrator, Program Manager, or Director at each Participating Agency will **inform the System Administrator of staff changes** within one business day of a staff member leaving the agency

  - Clients have the right to see their information on ServicePoint. If a client requests to see their information, the Participating Agency/User who receives the request must review the information with the client.

- **Persons to Enter into ServicePoint**

Adults and children who are homeless, as defined by the Department of Housing and Urban Development, will be entered into ServicePoint with informed/written consent.

- **Data Entry and Data Sharing**

Participating Agencies must collect the required set of data elements for each client. As outlined in the latest version of the HUD Data Standards, this includes the Universal and Program Specific Data Elements. In addition, Participating Agencies are required to review and update any/all data elements for each client served at the time of project entry, annual review and at exit.

Participating Agencies understand that only the individual who created the assessment screen (Coordinated Intake), or an authorized person by originating agency, has the ability to edit information within the assessment screen. Each Participating Agency will be responsible for completing a separate assessment, as needed, in order to accurately reflect changes to data for those clients served by the agency itself.

Protected Information: In the ServicePoint Record, there are certain services, referrals, and agencies not to be shared with other agencies.

1. Domestic Violence
2. HIV/Aids

Shared Information:

Each Participating Agency must complete and comply with the Agency Partnership Agreement.

Each individual HMIS user must complete and comply with the User Code of Ethics, Policy, and Responsibility Statements.

Each Participating Agency will have access to view all open client records and direct access to data entered by its own staff about the clients they serve. Written consent must be given by clients in order for their identifying information to be entered into HMIS and shared among agencies.

- Each Participating Agency must conduct periodic reviews to ensure appropriate written documentation (Client Release of Information) indicating client consent of data entered into HMIS.
- Identifying client information will only be shared among agencies that have signed the Agency Partnership Agreement (CoC Memorandum of Understanding). At any time, the client has the right to see a current list of CoC participating agencies.
- Additional agencies may join with notification and consent of the CoC Lead Agency.
- HMIS Users will maintain HMIS data in such a way as to protect against revealing the identity of clients to unauthorized agencies, individuals, or entities.
- No information will be entered for clients currently fleeing or in danger from a domestic violence situation.
- Clients may choose to no longer participate in HMIS at any time but must notify the Participating Agency via a signed "Consent to Rescind Participation in HMIS" form. This form must be submitted to the HMIS System Administrator.
- Clients may not be denied services based on their choice to withhold their consent.
- Participating agencies must maintain a comprehensive record (hard copy or electronic) for each client refusing/rescinding authorization to participate in HMIS.
- De-identified data may be used for the purposes of evaluation and research.

Children's Data

Information about clients who are under the age of 18 is always restricted. It is the User's responsibility to designate the information as "closed". Children's data may be shared if a parent or guardian lists the child on a signed "Release of Information Authorization" form.

Data Integrity: Data is the most valuable asset of the HMIS Project. It is our policy to protect this asset from accident or intentional unauthorized modification, disclosure or destruction.

Access to Client Records: The Client Records Access policy is designed to protect against the recording of information in unauthorized locations or systems. Only staff that work directly with clients or who have administrative responsibilities will receive authorization to look at, enter, or edit client records. Additional privacy protection policies include:

- Client has the right to not answer any question, unless entry into a service project requires it.
- Client has the right to know who has added to, deleted, or edited their client record.
- Client information transferred from one authorized location to another over the web is transmitted through a secure, encrypted connection.
- Client information is stored in an encrypted database.

Quality Assurance

Participating Agencies are responsible for timely, accurate and complete entry of client-level data.

- Central Intake (CI) is responsible for obtaining and entering the initial, complete data set for all individuals or family members served. CI will also enter all appropriate client referrals to CoC Participating Agencies.
- The Participating Agency, receiving referrals, will review and enter information in HMIS about individuals participating in an agency project.
- The Participating Agency <u>will not</u> enter fictitious or misleading data on an individual or household. Nor will the agency enter data that misrepresents the number of clients served or beds provided.
- Each Participating Agency will strive for real-time, or close to real-time, data entry. This is defined by either immediate data entry upon the client receiving an assessment or within <u>one</u> business day of the client assessment.
- Each Participating Agency must maintain a current copy of the Client Release of Information on file for each individual or family member served.
- The Participating Agency is responsible for each project's data quality within the respective provider tree and the percentage of "null/missing" and "unknown/don't know/refused/" values relative to HUD required elements.

See Data Quality Plan

End User Ethics: Any deliberate action that adversely affects the resources of any participating organization, institution, employees or individuals is prohibited. Users should not use the HMIS computing resources for personal purposes. Users must not attempt to gain physical or logical access to data or systems for which they are not authorized.

Computer Crime: Computer crimes violate State and Federal law as well as the Cleveland/Cuyahoga County HMIS security Policy and Procedures. They include but are not limited to: unauthorized disclosure, modification or destruction of data, programs or hardware; theft of computer services; illegal copying of software; invasion of privacy; theft of hardware, software, data, or printouts; promulgation of malicious software such as

viruses; and breach of contract. Perpetrators may be prosecuted under State and Federal law, held civilly liable for their actions, or both.

Application Software: Only tested and controlled software should be installed on networked systems. Use of unevaluated and untested software outside an application development environment is prohibited.

Technical Support

The System Administrator will be responsible for the training of all Participants in the use of ServicePoint. Cuyahoga County Information Services Center will maintain the server. Each Participating Agency is responsible for providing and maintaining computer hardware and Internet Service.

ServicePoint User Training

Prior to use, all users are required to attend ServicePoint Training sessions. All Agency Administrators are required to attend 2 days of Agency Administrator training. Agency Administrators will be responsible for training their staff. The HMIS System Administrator will provide quarterly trainings for all CoC HMIS End Users and will also be available to provide agency specific, End User Training upon request.

ResourcePoint Data

All Participants shall provide the System Administrator with the complete and current ResourcePoint Data about their agency's projects and services. The System Administrator will initially enter this into the database. Each Agency Administrator will be responsible for providing subsequent updates to the System Administrator.

ROLES AND RESPONSIBILITIES

HMIS Lead Agency
The HMIS Lead Agency, Cleveland/Cuyahoga County Office of Homeless Services (OHS), holds the contract with Bowman Systems for the use of ServicePoint. Under this agreement, OHS is the licensed administrator of ServicePoint which is managed by the System Administrator.

The HMIS System Administrator is responsible for:

- Providing training support to Participating Agencies by determining training needs of end users, developing training materials and conducting training sessions;
- Serving as the primary liaison with the HMIS vendor to advocate and resolve issues;
- Providing technical support by troubleshooting data with Participating Agencies;
- Managing user accounts and access;
- Managing system enhancements/updates and modifications;
- Fulfilling and assisting with reporting requirements for the CoC;
- Developing regular reports based on local CoC goals and objectives;
- Providing oversight of HUD/CoC quality and security standards;
- Working with CoC committees to coordinate the HMIS effort.

HMIS Participating Agencies
Any agency who participates in HMIS must complete an Agency Memorandum of Understanding and agree to abide by the policies and procedures outlined in this manual. Participating agencies are responsible for their client level data; furthermore, each agency is responsible for the integrity and security of their agency's client data.

Participating agencies are responsible for their agency end users and ensuring that they comply with the policies and procedures manual.

Each Participating Agency must designate an Agency Administrator and a backup Agency Administrator responsible for:

- Serving as the primary contact between their agency's end users and the HMIS System Administrator;
- Reporting any changes regarding HMIS Provider Profile Information to the HMIS System Administrator
- Providing technical support by troubleshooting data and escalating unresolved issues to the HMIS System Administrator;
- Notifying all of their agency end users of system updates, changes or other relevant information;
- Notifying HMIS System Administrator of personnel changes as it relates to HMIS;
- Conducting new and refresher trainings to agency end users;
- Assuring only trained, designated and licensed staff enter and maintain data;
- Monitoring compliance as outlined in the HUD Data Standards;

ATTACHMENT III

Written Standards for Order of Priority

written Standards

Prioritizing Persons Experiencing Chronic Homelessness in Permanent Supportive Housing

The Cuyahoga County CoC is committed to ending chronic homelessness. To accomplish this goal, the Office of Homeless Services Advisory Board has adopted the prioritization standards detailed in **CPD-14-012** to guide the allocation of CoC PSH resources. Following is a summary of the key sections of the **Notice.**

I. **Dedication and Prioritization of PSH Strategies to Increase the Number of PSH Beds Available for Chronically Homeless Persons**
   a) "Dedicated" PSH beds are those to be used only for chronically homeless persons. If there are no chronically homeless persons to fill a dedicated bed, a non-chronic homeless person may be housed; however, when that unit becomes vacant again, it will revert to a dedicated status;
   b) The CoC will give an admissions preference to chronically homeless persons for non-dedicated PSH beds. In the FY2013-2014 competition, CoC's were scored on the extent they committed to prioritizing chronically homeless persons to the level of 85% or more of their non –dedicated CoC funded, PSH . Based on the commitment made in FY 2014, CoC's may not revise the percentage to reduce the number of CH beds.

II. **Order of priority in CoC program –funded Permanent Supportive Housing DEDICATED to Persons Experiencing CH and PSH Prioritized for Occupancy by Persons Experiencing Chronic Homelessness and Permanent Supportive Housing Prioritized for Occupancy by Persons Experiencing Chronic Homelessness.**

   a) **First Priority**: CH individuals and families with the **longest history of homelessness** *and* with the **most severe service needs.**
   b) **Second Priority:** CH individuals and families with the **longest history of homelessness;**
   c) **Third Priority:** CH individuals and families with the **most severe service needs**
   d) **Fourth Priority:** All other CH individuals and families

III. **Order of Priority in Permanent Supportive Housing beds not dedicated or prioritized for persons experiencing chronic homelessness.**
   a) **First Priority**: Homeless Individuals and families with a **disability with the most severe service needs.**
   b) **Second Priority:** Homeless Individuals and families with a Disability with a long period of continuous or episodic Homelessness
   c) **Third Priority:** Homeless Individuals and families with Disability coming from places not meant for human habitation, Safe Havens, or Emergency Shelters;
   d) **Fourth Priority:** Homeless Individuals and families with a disability coming from Transitional Housing, including homeless individuals and households with children with a qualifying disability who are fleeing domestic violence, dating violence, sexual assault, or stalking and

are living in transitional housing even if they did not live on the streets, in shelter or a safe haven prior to entering the transitional housing.

IV. **Using a Coordinated Assessment and Standardized Assessment Tool or Process to Determine Eligibility and Establish a Prioritized Waiting List**

This Section covers the HEARTH Act requirements for CoC's to implement **Coordinated Assessment & Intake** and to use CE to develop a **Single Prioritized Waiting List for PSH**, based on a **Standardized Assessment Tool.**

V. **Record Keeping Requirements**

a) The CoC must comply with the HEARTH Act CFR 578.103 regarding written standards and in addition, should document the prioritization polices of this Notice ;
b) Evidence of the Assessment Tool
c) Evidence of polices being incorporated throughout the CoC's documentation
d) Documentation of evidence of homeless status
e) Documentation of duration of homelessness
f) Documentation of disability
g) Confirmation in CoC documents that it has complied with the Recordkeeping recommendations of the Notice.

U.S. Department of Housing and Urban Development
Office of Community Planning and Development

Special Attention of:	**Notice: CPD-14-012**
All Secretary's Representatives	**Issued: July 28, 2014**
All Regional Directors for CPD	**Expires:** This Notice is effective until it is amended, superseded, or rescinded
All CPD Division Directors	
Continuums of Care (CoC)	
Recipients of the Continuum of Care (CoC) Program	**Cross Reference:** 24 CFR Parts 578 and 42 U.S.C. 11381, *et seq.*

Subject: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status

Table of Contents

I. Purpose

This Notice provides guidance to Continuums of Care (CoC) and recipients of Continuum of Care (CoC) Program (24 CFR part 578) funding for permanent supportive housing (PSH) regarding the order in which eligible households should be served in **all** CoC Program-funded PSH. This Notice also establishes recordkeeping requirements for all recipients of CoC Program-funded PSH that includes beds that are required to serve persons experiencing chronic homelessness as defined in 24 CFR 578.3, in accordance with 24 CFR 578.103.

A. Background

In June 2010, the Obama Administration released *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* (*Opening Doors*), in which HUD and its federal partners set goals to end Veteran and chronic homelessness by 2015, and end family and youth homelessness by 2020. Ending chronic homelessness is the first goal of *Opening Doors* and is a top priority for HUD. Although progress has been made there is still a long way to go. In 2013, there were still 109,132 people identified as chronically homeless in the United States. In order to meet the first goal of *Opening Doors*–ending chronic homelessness–it is critical that CoCs ensure that limited resources awarded through the CoC Program Competition are being used in the most effective manner and that households that are most in need of assistance are being prioritized.

Since 2005, HUD has encouraged CoCs to create new PSH dedicated for use by persons experiencing chronic homelessness (herein referred to as dedicated PSH). As a result, the number of dedicated PSH beds for persons experiencing chronic homelessness has increased from 24,760 in 2007 to 51,142 in 2013. This increase has contributed to a 25 percent decrease in the number of chronically homeless persons reported in the Point-in-Time Count between 2007 and 2013. Despite the overall increase in the number of dedicated PSH beds, this only represents 30 percent of all CoC Program-funded PSH beds.

To ensure that all PSH beds funded through the CoC Program are used as strategically and effectively as possible, PSH needs to be targeted to serve persons with the highest needs and greatest barriers towards obtaining and maintaining housing on their own–persons experiencing chronic homelessness. HUD's experience has shown that many communities and recipients of CoC Program-funded PSH continue to serve persons on a "first-come, first-serve" basis and/or based on tenant selection processes that screen-in those who are most likely to succeed. These approaches to tenant selection have not been effective in reducing chronic homelessness, despite the increase in the number of PSH beds nationally.

B. Goal of this Notice

The overarching goal of this Notice is to ensure that the homeless individuals and families with the most severe service needs within a community are prioritized in PSH, which will also increase progress towards the Obama Administration's goal of ending chronic homelessness. In order to guide CoCs in ensuring that all CoC Program-funded PSH beds are used most effectively, this Notice establishes an order of priority which CoCs are strongly encouraged to adopt and incorporate into the CoC's written standards and

coordinated assessment system. With adoption by CoCs and incorporation into the CoC's written standards, **all** recipients of CoC Program-funded PSH must then follow this order of priority, consistent with their current grant agreement, which will result in this intervention being targeted to the persons who need it the most. Such adoption and incorporation will ensure that persons are housed appropriately and in the order provided in this Notice.

HUD seeks to achieve three goals through this Notice:

1. Establish an order of priority for dedicated and prioritized PSH beds which CoCs are encouraged to adopt in order to ensure that those persons with the most severe service needs are given first priority.

2. Inform the selection process for PSH assistance not dedicated or prioritized for chronic homelessness to prioritize persons who do not yet meet the definition of chronic homelessness but are most at risk of becoming chronically homeless.

3. Provide uniform recordkeeping requirements for all recipients of CoC Program-funded PSH for documenting chronically homeless status of program participants when required to do so as well as provide guidance on recommended documentation standards that CoCs may require of its recipients of CoC Program-funded PSH if the priorities included in the Notice are adopted by the CoC.

C. Applicability

The guidance in this Notice is provided to all CoCs and all recipients and subrecipients–the latter two groups referred to collectively as recipients of CoC Program-funded PSH. CoCs are encouraged to incorporate the order of priority described in this Notice into their written standards, in accordance with the CoC Program interim rule at 24 CFR 578.7(a)(9) and 24 CFR 578.93, for CoC Program-funded PSH. Upon incorporation of the order of priority into written standards CoCs may then require recipients of CoC Program-funded PSH to follow the order of priority in accordance with the CoC's revised written standards and this Notice and in a manner consistent with their current grant agreement.

D. Key Terms

1. **Housing First.** Housing First is an approach in which housing is offered to people experiencing homelessness without preconditions (such as sobriety, mental health treatment, or a minimum income threshold) or service participation requirements and in which rapid placement and stabilization in permanent housing are primary goals. PSH projects that use a Housing First approach promote the acceptance of applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services. HUD encourages all recipients of CoC Program-funded PSH to follow a Housing First approach to the maximum extent practicable. Any recipient that indicated that they would follow a Housing First approach in the FY 2013 CoC Project Application must do so for both the FY 2013 and FY 2014 operating year(s), as the CoC score for the FY 2013–FY 2014 CoC Program Competition was affected by the extent in which project applications indicated that they would follow this approach and this requirement will be incorporated into the recipient's FY 2013 and FY 2014 grant agreement.

HUD recognizes that this approach may not be applicable for all program designs, particularly for those projects formerly awarded under the SHP or SPC programs which were permitted to target persons with specific disabilities (e.g., "sober housing").

2. **Chronically Homeless.** The definition of "chronically homeless" currently in effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:

   (a) An individual who:

      i. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

      ii. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and

      iii. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

   (b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility; or

   (c) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice, including a family whose composition has fluctuated while the head of household has been homeless.

3. **Severity of Service Needs.** This Notice refers to persons who have been identified as having the most severe service needs.

   (a) For the purposes of this Notice, this means an individual for whom at least one of the following is true:

      i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; or

      ii. Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.

Severe service needs as defined in paragraphs i. and ii. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool that can identify the severity of needs such as the Vulnerability Index (VI), the Service Prioritization Decision Assistance Tool (SPDAT), or the Frequent Users Service Enhancement (FUSE). The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual.

(b) In states where there is an alternate criteria used by state Medicaid departments to identify high-need, high cost beneficiaries, CoCs and recipients of CoC Program-funded PSH may use similar criteria to determine if a household has severe service needs instead of the criteria defined paragraphs i. and ii. above. However, such determination must not be based on a specific diagnosis or disability type.

II. Dedication and Prioritization of Permanent Supportive Housing Strategies to Increase Number of PSH Beds Available for Chronically Homeless Persons

There are two significant ways in which CoCs can increase progress towards ending chronic homelessness in their communities using only their existing CoC Program-funded PSH:

A. Increase the number of CoC Program-funded PSH beds that are dedicated to persons experiencing chronic homelessness.

Dedicated PSH beds are required through the project's grant agreement to only be used to house persons experiencing chronic homelessness unless there are no persons within the CoC that meet that criteria. If this occurs, the recipient may then follow the order of priority in this Notice if it is adopted by the CoC. The bed will continue to be a dedicated bed, however, so when that bed becomes vacant again it must be used to house a chronically homeless person unless there are still no persons who meet that criterion within the CoC's geographic area. These PSH beds are reported as "CH Beds" on a CoC's Housing Inventory Count (HIC). A CoC may increase the number of CoC Program-funded PSH beds that are dedicated to persons experiencing chronic homelessness when it's recipients of non-dedicated CoC Program-funded PSH request a grant amendment to dedicate one or more of its beds for this purpose. A recipient of CoC Program-funded PSH is prohibited from changing the designation of the bed from dedicated to non-dedicated without a grant agreement amendment. Similarly, if a recipient of non-dedicated PSH intends to dedicate one or more of its beds to the chronically homeless it may do so through a grant agreement amendment.

B. Prioritize non-dedicated PSH beds for use by persons experiencing chronic homelessness.

Prioritization means implementing an admissions preference for chronically homeless persons for CoC Program-funded PSH beds. In the FY 2013-FY 2014 CoC Program Competition, CoCs were scored on the extent to which they were willing to commit to prioritizing chronically homeless persons in a percentage of their non-dedicated PSH beds with the highest points going to CoCs that committed to prioritize the chronically homeless

in 85 percent or more of their non-dedicated CoC Program-funded PSH. Further, project applicants for CoC Program-funded PSH had to indicate the number of non-dedicated beds that would be prioritized for use by persons experiencing chronic homelessness. These projects are now required to prioritize chronically homeless persons in their non-dedicated CoC Program-funded PSH beds for FY 2013 and FY 2014, as the project application is incorporated into the grant agreement. PSH beds that were included in the calculation for the CoCs commitment in the CoC Application cannot revise their FY 2014 application to reduce the number of prioritized beds; however, recipients of PSH that are currently not dedicated to the chronically homeless may choose to prioritize additional beds in the FY 2014 CoC Project Application. All recipients of CoC Program-funded PSH are encouraged to prioritize the chronically homeless as beds become vacant to the maximum extent practicable. CoCs will be expected to meet or exceed the goals established in the FY 2013/FY 2014 CoC Application and should continue to prioritize persons experiencing chronic homelessness in their CoC Program-funded PSH until there are no persons within the CoC's geographic area who meet that criteria. Further, to the extent that CoCs incorporate this order of priority into the CoCs written standards, recipients of CoC Program-funded PSH will also be required to follow this criterion included in those standards.

III. Order of Priority in CoC Program-funded Permanent Supportive Housing

A. Order of Priority in CoC Program-funded Permanent Supportive Housing Beds Dedicated to Persons Experiencing Chronic Homelessness and Permanent Supportive Housing Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

1. As of the date of this Notice, CoCs are encouraged to revise their written standards to include the following order of priority for CoC Program-funded PSH that is either dedicated or prioritized for use by the chronically homeless. If adopted into the CoCs written standards, recipients of CoC Program-funded PSH would then be required to follow the order of priority when selecting participants for housing in accordance with the CoC's revised written standards in accordance with this Notice and in a manner consistent with their current grant agreement. For CoC Program-funded PSH that is dedicated or prioritized for persons experiencing chronic homelessness, the following order of priority is strongly encouraged:

   (a) **First Priority–Chronically Homeless Individuals and Families with the Longest History of Homelessness and with the Most Severe Service Needs.** A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

      i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and

ii. The CoC or CoC Program recipient has identified the chronically homeless individual or head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs (see Section I.D.3. of this Notice for definition of severe service needs).

(b) **Second Priority–Chronically Homeless Individuals and Families with the Longest History of Homelessness.** A chronically homeless individual or head of household, as defined in 24 CFR 578.3, for which both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and,

ii. The CoC or CoC program recipient has <u>not</u> identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

(c) **Third Priority–Chronically Homeless Individuals and Families with the Most Severe Service Needs.** A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living or residing 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 total length of those separate occasions equals less than one year; and

ii. The CoC or CoC program recipient has identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

(d) **Fourth Priority–All Other Chronically Homeless Individuals and Families.** A chronically homeless individual or head of household as defined in 24 CFR 578.3 for whom both of the following are true:

i. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for on at least four separate occasions in the last 3 years, where the cumulative total length the four

occasions is **less than** 12 months; and

ii. The CoC or CoC program recipient has not identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

2. Where a CoC or a recipient of CoC Program-funded PSH beds that are dedicated or prioritized is not able to identify chronically homeless individuals and families as defined in 24 CFR 578.3 within the CoC, the order of priority in Section III.B. of this Notice, as adopted by the CoC, may be followed.

3. Recipients of CoC Program-funded PSH should follow the order of priority above while also considering the goals and any identified target populations served by the project. For example, a CoC Program-funded PSH project that is permitted to target homeless persons with a serious mental illness that has been identified as a project that will prioritize a portion or all of its turnover beds to persons experiencing chronic homelessness should follow the order of priority under Section III.A.1. of this Notice to the extent in which persons with serious mental illness meet the criteria.

4. Recipients must exercise due diligence when conducting outreach and assessment to ensure that persons are served in the order of priority in this Notice. HUD recognizes that some persons–particularly those living on the streets or in places not meant for human habitation–might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units remain vacant where there are persons who meet a higher priority within the CoC and who have not yet accepted the PSH opportunities offered to them. Street outreach providers should continue to make attempts to engage those persons and the CoC and CoC Program-funded PSH providers are encouraged to follow a Housing First approach to the maximum extent practicable and for those projects that indicated in the FY 2013 CoC Project Application that they would follow a Housing First approach will be required to do so for both the FY 2013 and FY 2014 operating year(s), as the CoC score for the FY 2013–FY 2014 CoC Program Competition was affected by the extent in which project applications indicated that they would follow this approach and this requirement will be incorporated into the recipient's FY 2013 and FY 2014 grant agreement. For eligibility in dedicated or prioritized PSH serving chronically homeless households, the individual or head of household must meet all of the applicable criteria to be considered chronically homeless per 24 CFR 578.3.

B. Order of Priority in Permanent Supportive Housing Beds Not Dedicated or Prioritized for Persons Experiencing Chronic Homelessness

1. As of the date of this Notice, CoCs are encouraged to revise their written standards to include the following priorities for non-dedicated and non-prioritized PSH beds. If adopted into the CoCs written standards, recipients of CoC Program-funded PSH would then be required to follow the order of priority when selecting participants for housing in accordance with the CoC's revised written standards included in this Notice and in a

manner consistent with their current grant agreement. CoCs that adopt this order of priority are encouraged to include in the written standards a policy that would allow for recipients of non-dedicated and non-prioritized PSH to offer housing to chronically homeless individuals and families first, but minimally would be required to place otherwise eligible households in an order that prioritizes, in a nondiscriminatory manner, those who would benefit the most from this type of housing, beginning with those most at risk of becoming chronically homeless. For eligibility in non-dedicated and non-prioritized PSH serving non-chronically homeless households, any household member with a disability may qualify the family for PSH.

(a) **First Priority–Homeless Individuals and Families with a Disability with the Most Severe Service Needs.**

An individual or family that is eligible for CoC Program-funded PSH who has been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for any period of time, including persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution **and** has been identified as having the most severe service needs.

(b) **Second Priority–Homeless Individuals and Families with a Disability with a Long Period of Continuous or Episodic Homelessness.** An individual or family that is eligible for CoC Program-funded PSH who has been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 6 months or on at least three separate occasions in the last 3 years where the cumulative total is at least 6 months. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution and had been living or residing in one of those locations for at least 6 months or on at least three separate occasions in the last 3 years where the cumulative total is at least 6 months.

(c) **Third Priority–Homeless Individuals and Families with Disability Coming from Places Not Meant for Human Habitation, Safe Havens, or Emergency Shelters.** An individual or family that is eligible for CoC Program-funded PSH who has been living in a place not meant for human habitation, a safe haven, or an emergency shelter. This includes persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution.

(d) **Fourth 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 coming from transitional housing, where prior to residing in the transitional housing lived on streets or in an emergency shelter, or

safe haven. This priority also includes homeless individuals and homeless households with children with a qualifying disability who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and are living in transitional housing–all are eligible for PSH even if they did not live on the streets, emergency shelters, or safe havens prior to entry in the transitional housing.

2. Recipients of CoC Program-funded PSH should follow the order of priority above, as adopted by the CoC, while also considering the goals and any identified target populations served by the project. For example, in CoC Program-funded PSH where the beds are not dedicated or prioritized and which is permitted to target homeless persons with a serious mental illness should follow the order of priority under Section III.B.1. of this Notice, as adopted by the CoC, to the extent in which persons with serious mental illness meet the criteria.

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

IV. Using a Coordinated Assessment and a Standardized Assessment Tool or Process to Determine Eligibility and Establish a Prioritized Waiting List

A. Coordinated Assessment Requirement

Provisions at 24 CFR 578.7(a)(8) requires that each CoC, in consultation with recipients of Emergency Solutions Grants (ESG) program funds within the CoC's geographic area, 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. CoCs that adopt the order of priority in Section III of this Notice into the CoC's written standards are strongly encouraged to use their coordinated assessment system in order to ensure that there is a single prioritized waiting list for all CoC Program-funded PSH within the CoC. Under no circumstances shall the order of priority be based upon diagnosis or disability type, but instead on the severity of needs of an individual or family.

B. Written Standards for Creation of a Single Prioritized Waiting List for PSH

CoCs are also encouraged to include in their policies and procedures governing their coordinated assessment system, a requirement that all CoC Program-funded PSH accept referrals only through a single prioritized waiting list that is created through the CoCs coordinated assessment process. Adopting this into the CoC's policies and procedures for coordinated assessment would further ensure that CoC Program-funded PSH is being used most effectively, which is one of the goals in this Notice. This would also allow for

recipients of CoC Program funds for PSH to maintain their own waiting lists, but all households would be referred olds to each of those project-level waiting lists based on where they fall on the prioritized list and not on the date in which they first applied for housing assistance.

C. Standardized Assessment Tool Requirement

CoCs must utilize a standardized assessment tool, in accordance with 24 CFR 578.3, or process. Appendix A of this Notice–*Coordinated Assessment Tool and Implementation: Key Considerations*–provides recommended criteria for a quality coordinated assessment process and standardized assessment tool.

D. Nondiscrimination Requirements

CoCs and recipients of CoC Program-funded PSH must continue to comply with the nondiscrimination provisions of Federal civil rights laws, including, but not limited to, the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Titles II or III of the Americans with Disabilities Act, as applicable.

V. Recordkeeping Requirements

This Notice establishes recordkeeping requirements for all recipients of CoC Program-funded PSH that are required to document a program participant's status as chronically homeless as defined in 24 CFR 578.3 and in accordance with 24 CFR 578.103. Further, HUD expects that where CoCs have adopted the orders of priority in Section III. of this Notice into their written standards, the CoC as well as recipients of CoC Program-funded PSH, will maintain evidence of implementing these priorities.

A. CoC Records

In addition to the records required in 24 CFR 578.103, it is recommended that the CoC should supplement such records with the following:

1. **Evidence of written standards that incorporate the priorities in Section III. of this Notice, as adopted by the CoC.** A CoC adopting the priorities in Section III of this Notice, may be evidenced by written CoC, or subcommittee, meeting minutes where written standards were adopted that incorporate the prioritization standards in this Notice, or an updated, approved, governance charter where the written standards have been updated to incorporate the prioritization standards set forth in this Notice.

2. **Evidence of a standardized assessment tool.** Use of a standardized assessment tool may be evidenced by written policies and procedures referencing a single standardized assessment tool that is used by all CoC Program-funded PSH recipients within the CoC's geographic area.

3. **Evidence that the written standards were incorporated into the coordinated assessment policies and procedures.** Incorporating standards into the coordinated assessment policies and procedures may be evidenced by updated policies and

procedures–that incorporate the updated written standards for CoC Program-funded PSH developed and approved by the CoC.

B. Recipient Recordkeeping Requirements

In addition to the records required in 24 CFR 578.103, recipients of CoC Program-funded PSH that is required by grant agreement to document chronically homeless status of program participants in some or all of its PSH beds must maintain the following records:

1. **Written Intake Procedures.** Recipients must maintain and follow written intake procedures to ensure compliance with the definition of chronically homeless per 24 CFR 578.3. These procedures must establish the order of priority for obtaining evidence as: (1) third-party documentation, (2) intake worker observations, and (3) certification from the person seeking assistance. Records contained in an HMIS or comparable database used by victim service or legal service providers are acceptable evidence of third-party documentation and intake worker observations if the HMIS retains an auditable history of all entries, including the person who entered the data, the date of entry, and the change made; and if the HMIS prevents overrides or changes of the dates entries are made.

2. **Evidence of Chronically Homeless Status.** Recipients of CoC Program-funded PSH whose current grant agreement includes beds that are dedicated or prioritized to the chronically homeless must maintain records evidencing that the individuals or families receiving the assistance in those beds meets the definition for chronically homeless at 24 CFR 578.3. Such records must include evidence of the homeless status of the individual or family (paragraphs (1)(i) and (1)(ii) of the definition), the duration of homelessness (paragraph (1)(ii) of the definition), and the disabling condition (paragraph (1)(iii) of the definition). When applicable, recipients must also keep records demonstrating compliance with paragraphs (2) and (3) of the definition.

   (a) **Evidence of homeless status.** Evidence of an individual or head of household's current living situation may be documented by a written observation by an outreach worker, a written referral by housing or service provider, or a certification by the household seeking assistance that demonstrates that the individual or head of household is currently homeless and living in a place not meant for human habitation, in an emergency shelter, or a safe haven. For paragraph (2) of the definition for chronically homeless at 24 CFR 578.3, for individuals currently residing in an institution, acceptable evidence includes:

      i. Discharge paperwork or a written or oral referral from a social worker, case manager, or other appropriate official of the institution, stating the beginning and end dates of the time residing in the institution that demonstrate the person resided there for less than 90 days. All oral statements must be recorded by the intake worker; or

      ii. Where the evidence above is not obtainable, a written record of the intake worker's due diligence in attempting to obtain the evidence described in the paragraph i. above and a certification by the individual seeking

assistance that states that they are exiting or have just exited an institution where they resided for less than 90 days; and

iii. Evidence that the individual was homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter, and met the criteria in paragraph (1) of the definition for chronically homeless in 24 CFR 578.3, immediately prior to entry into the institutional care facility.

(b) **Evidence of the duration of the homelessness.** Recipients documenting chronically homeless status must also maintain the evidence described in paragraph i. or in paragraph ii. below, and the evidence described in paragraph iii. below:

i. **Evidence that the homeless occasion was continuous, for at least one year.**

Using any combination of allowable documentation described in Section V.B.2.(a) of this Notice, recipients must provide evidence that the homeless occasion was continuous, for a year period, without a break in living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter. For the purposes of this Notice, a break is considered at least seven or more consecutive nights not residing in a place not meant for human habitation, in shelter, or in a safe haven.

At least 9 months of the 1-year period must be documented by one of the following: (1) HMIS data, (2), a written referral, or (3) a written observation by an outreach worker. In only rare and the most extreme cases, HUD would allow a certification from the individual or head of household seeking assistance in place of third-party documentation for up to the entire period of homelessness. Where third-party evidence could not be obtained, the intake worker must obtain a certification from the individual or head of household seeking assistance, and evidence of the efforts made to obtain third-party evidence as well as documentation of the severity of the situation in which the individual or head of household has been living. An example of where this might occur is where an individual has been homeless and living in a place not meant for human habitation in a secluded area for more than 1 year and has not had any contact with anyone during that entire period.

Note: A single encounter with a homeless service provider on a single day within 1 month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month (e.g., evidence in HMIS of a stay in transitional housing).

ii. Evidence that the household experienced at least four separate homeless occasions over 3 years.

Using any combination of allowable documentation described in Section V.B.2.(a) of this Notice, the recipient must provide evidence that the head of household experienced at least four, separate, occasions of homelessness in the past 3 years.

Generally, at least three occasions must be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Any other occasion may be documented by a self-certification with no other supporting documentation.

In only rare and the most extreme cases, HUD will permit a certification from the individual or head of household seeking assistance in place of third-party documentation for the three occasions that must be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Where third-party evidence could not be obtained, the intake worker must obtain a certification from the individual or head of household seeking assistance, and must document efforts made to obtain third-party evidence, and document of the severity of the situation in which the individual has been living. An example of where this might occur is where an individual has been homeless and living in a place not meant for human habitation in a secluded area for more than one occasion of homelessness and has not had any contact with anyone during that period.

iii. Evidence of diagnosis with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability. Evidence of this criterion must include one of the following:

(1) Written verification of the condition from a professional licensed by the state to diagnose and treat the condition;

(2) Written verification from the Social Security Administration;

(3) Copies of a disability check (e.g., Social Security Disability Insurance check or Veterans Disability Compensation);

(4) Intake staff (or referral staff) observation that is 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 of the application for assistance and accompanied with one of the types of evidence above; or

(5) Other documentation approved by HUD.

C. Recordkeeping Recommendations for CoCs that have Adopted the Order of Priority in this Notice.

Where CoCs have incorporated the order of priority in this Notice into their written standards, recipients of CoC Program-funded PSH may demonstrate that they are following the CoC-established requirement by maintaining the following evidence:

1. **Evidence of Cumulative Length of Occasions.** For recipients providing assistance to households using the selection priority in Sections III.A.1(a) and (b) of this Notice, the recipient must maintain the evidence of each occasion of homelessness as required in Section V.B.2.(b)(2) of this Notice, which establishes how evidence of each occasion of homelessness, when determining whether an individual or family is chronically homeless, may be documented. However, to properly document the length of time homeless, it is important to document the start and end date of each occasion of homelessness and these occasions must cumulatively total a period of 12-months. In order to properly document the cumulative period of time homeless, at least 9 months of the 12-month period must be documented through third-party documentation unless it is one of the rare and extreme cases described in Section V.B.2.b.ii. of this Notice. For purposes of this selection priority, a single encounter with a homeless service provider on a single day within one month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month (e.g., evidence in HMIS of a stay in transitional housing).

2. **Evidence of Severe Service Needs.** Evidence of severe service needs is that by which the recipient is able to determine the severity of needs as defined in Section I.D.3. of this Notice using data-driven methods such as an administrative data match or through the use of a standardized assessment conducted by a qualified professional.

3. **Evidence that the Recipient is Following the CoC's Written Standards for Prioritizing Assistance.** Recipients must follow the CoC's written standards for prioritizing assistance, as adopted by the CoC. In accordance with the CoC's adoption of written standards for prioritizing assistance, recipients must in turn document that the CoC's revised written standards have been incorporated into the recipient's intake procedures and that the recipient is following its intake procedures when accepting new program participants into the project.

VI. Questions Regarding this Notice

Questions regarding this notice should be submitted to HUD's Ask A Question at: www.onecpd.info/get-assistance/my-question.

Appendix A

Coordinated Assessment Process and Standardized Assessment Tool: Key Considerations

A coordinated assessment process is intended to increase and streamline access to housing and services for households experiencing homelessness, matches appropriate levels of housing and services based on their needs, and prioritizes persons with severe service needs for the most intensive interventions. HUD will be issuing guidance regarding the minimum requirements for establishing and operating a coordinated assessment system, as required by 24 CFR 578.7(a)(8), separately. Meanwhile, this Appendix is intended to help inform CoC efforts to implement an effective coordinated assessment *process* and qualities of an effective standardized assessment tool. As stated in Section III of this Notice, the use of both a coordinated assessment process and assessment tool(s) are critical to effectively implement the order of priority described in Section III.A. and III.B., if adopted by the CoC and incorporated into the CoCs written standards.

Recommendations for Effective Implementation of a Coordinated Assessment Process

The coordinated assessment process must incorporate and defer to any funding requirements established under the CoC Program interim rule, ESG Program interim rule, or a Notice of Funding Availability under which a project is awarded. In addition, the following are recommended as the minimum criteria for the effective implementation of a coordinated assessment process.

1. **Standardized**–The assessment process should rely upon a standardized method and criteria to determine the appropriate type of intervention for individuals or families. This standardized process could encompass the CoC-wide use of a standardized assessment tool, as well as data driven methods.

2. **Improves data management**–Individual tracking, resource allocation and planning, system monitoring, and reporting to the community and to funders is improved by use of a common, coordinated assessment tool.

3. **Non-directive**–The recommendations of the tool can be overridden by the judgment of qualified professionals, especially in where there are extenuating circumstances that are not assessed by the tool are relevant to choosing appropriate interventions. Discretion must be exercised in a nondiscriminatory manner consistent with fair housing and civil rights laws and should be subject to appropriate review and documentation (see Section V. of this Notice for the recordkeeping requirements), to ensure it is applied judiciously.

4. **Mainstream resources**–Effective coordinated assessment facilitates meaningful coordination between the homeless response system and the intake processes for mainstream systems. Connections should be made to public housing authorities, multifamily housing, health and mental health care, the workforce development system, and with other mainstream income and benefits as appropriate and applicable.

5. **Align Interventions**–The various types of interventions that are available are aligned and used strategically.

6. **Leverage local attributes and capacity**–The physical and political geography, including the capacity of partners in a community, and the opportunities unique to the community's context, should inform local coordinated assessment implementation.

7. **Assess program capacity**–Assess the variety and capacity of programs in the community to identify and fill critical gaps in housing and service resources and to ensure that a there is a range of options needed for a coordinated assessment system to work well.

8. **Outreach**–The coordinated assessment system should ensure that connections and ongoing engagement occurs with those not accessing services and housing on their own. Often, these are the highest need and most at-risk people in communities.

9. **Privacy protections**–Protections should be in place to ensure proper use of the information with consent from the client. Assessment should also be conducted in a private location.

10. **Fair Housing and Civil Rights**—Protections should be in place to ensure compliance with all civil rights requirements, including, but not limited to, the Fair Housing Act, Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973. The assessment tool should not seek disability-related information that is unnecessary for determining the need for housing-related services. The coordinated assessment process should ensure that program participants are informed of rights and remedies available under applicable federal, state, and local fair housing and civil rights laws, in accordance with the requirement at 24 CFR 578.93(c)(3).

11. **Training**–Initial and ongoing training on the use of the assessment tool should be provided to those parties that will be administering the assessment.

12. **Accessible and well-advertised**–The assessment must be well advertised and easily accessed by people seeking services or housing. This can happen in a variety of ways: access to services can be centralized, a one-stop shop approach. Access can be coordinated, leveraging outreach capacity and linking or integrating with mainstream systems. The assessment must be conducted in a manner that is accessible for individuals with disabilities, ensures meaningful program access for persons with Limited English Proficiency, and is affirmatively marketed in order to reach eligible persons who are least likely to seek assistance in the absence of special outreach, in accordance with 24 CFR 578.93(c)(1).

13. **Prioritization**–When resources are scarce, the coordinated assessment process should prioritize who will receive assistance based on their needs. Coordinated assessment should never result in long waiting lists for assistance. Instead, when there are many more people who are assessed to receive an intervention than there are available openings, the process should refer only individuals with the greatest needs.

14. **Inform system change efforts**–Information gathered during the coordinated assessment process should identify what types of programs are most needed in the community and be used by the CoC and other community leaders to allocate resources.

Recommended Qualities of a Good Standardized Assessment Tool

While HUD requires that CoCs use a standardized assessment tool, it does not endorse any specific tool or approach, there are universal qualities that any tool used by a CoC for their coordinated assessment process should include.

1. **Valid**–Tools should be evidence-informed, criteria-driven, tested to ensure that they are appropriately matching people to the right interventions and levels of assistance, responsive to the needs presented by the individual or family being assessed, and should make meaningful recommendations for housing and services.

2. **Reliable**–The tool should produce consistent results, even when different staff members conduct the assessment or the assessment is done in different locations.

3. **Inclusive**–The tool should encompass the full range of housing and services interventions needed to end homelessness, and where possible, facilitate referrals to the existing inventory of housing and services.

4. **Person-centered**–Common assessment tools put people–not programs–at the center of offering the interventions that work best. Assessments should provide options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need. High value and weight should be given to clients' goals and preferences.

5. **User-friendly**–The tool should be brief, easily administered by non-clinical staff including outreach workers and volunteers, worded in a way that is easily understood by those being assessed, and minimize the time required to utilize.

6. **Strengths-based**–The tool should assess both barriers **and** strengths to permanent housing attainment, incorporating a risk and protective factors perspective into understanding the diverse needs of people.

7. **Housing First orientation**–The tool should use a Housing First frame. The tool should not be used to determine "housing readiness" or screen people out for housing assistance, and therefore should not encompass an in-depth clinical assessment. A more in-depth clinical assessment can be administered once the individual or family has obtained housing to determine and offer an appropriate service package.

8. **Sensitive to lived experiences**–Providers should recognize that assessment, both the kinds of questions asked and the context in which the assessment is administered, can cause harm and risk to individuals or families, especially if they require people to relive difficult experiences. The tool's questions should be worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people experiencing homelessness. The tool should minimize risk and harm, and allow individuals or families to refuse to answer questions. Agencies administering the assessment should have and follow protocols to address any psychological impacts caused by the assessment and should administer the assessment in a private space, preferably a room with a door, or, if outside, away from others' earshot. Those administering the tool should be trained to recognize signs of trauma or anxiety.

Additionally, the tool should link people to services that are culturally sensitive and appropriate and are accessible to them in view of their disabilities, *e.g.*, deaf or hard of hearing, blind or low vision, mobility impairments

9. **Transparent**–The relationship between particular assessment questions and the recommended options should be easy to discern. The tool should not be a "black box" such that it is unclear why a question is asked and how it relates to the recommendations or options provided.