Centralized Access System (CAS)
Arlington County, VA

Prevention, Diversion, Housing and Homeless Programming

Operating Policies and Procedures
October 11, 2017

Contents

Section I - Introduction

Background

Arlington County's Continuum of Care (CoC) has a 10 Year Plan to End Homelessness (10YR) which utilizes best practice models designed to prevent homelessness and to

address homelessness for all populations, families, individuals, and the chronically homeless.

The 10YR, aligns with the federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. HEARTH has established goals and objectives targeted at ending chronic homelessness and reducing all homelessness. To achieve the goals of the Plan, the Arlington County Consortium (ACC) has aligned resources at the federal, state, and local levels with the performance outcomes outlined in the HEARTH Act, which include:

- Reducing the number of people who become homeless
- Reducing the length of homelessness
- Reducing the returns to homelessness
- Reducing overall homelessness

According to the National Alliance to End Homelessness, coordinated assessment, also known as coordinated entry, centralized intake process, or coordinated intake, paves the way for more efficient homeless assistance systems by:

- helping people move through the system more efficiently (by reducing the amount of time people spent moving from program to program before finding the right match);

- reducing new entries into homelessness (by consistently offering prevention and diversion resources upfront, reducing the number of people entering the system unnecessarily); and

- improving data collection and quality and providing accurate information on what kind of assistance consumers need.

Arlington County and other participating stakeholders used the following guiding principles to aid in the systems' planning and design, implementation processes, and ongoing management of the Centralized intake process. The system will:

- Allow anyone who needs assistance from the homeless services system to know where to go to access services, be assessed in a standard and consistent way, and to connect with the housing/services that best meet their needs;
- Ensure clarity, transparency, consistency, and accountability for homeless clients, referral sources, and homeless service providers throughout the assessment and referral process;
- Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources;
- Ensure that clients gain access as efficiently and effectively as possible to the type of intervention most appropriate to their immediate and long-term housing needs and preferences;

- Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce emergency shelter and permanent supportive housing resources;
- Establish standard, consistent eligibility criteria and prioritization standards;
- Retain program flexibility to the extent possible; limit eligibility criteria to those required by funding sources;
- Incorporate provider discussion in enrollment decisions;
- Promote collaboration, communication, and sharing of knowledge regarding resources among providers;
- Leverage HMIS data and infrastructure whenever possible to expedite processes;
- Limit data collection to that which is relevant to the process;
- Ensure staff conducting assessments are trained and competent in assessment.

Centralized intake plays an essential role in that ideal system, and in getting to that ideal system. The data generated from centralized intake describes who is getting what they need from our system, who is not, and where we need to invest our resources to realize our shared goal of ending homelessness. Beginning in FY2015, both the state and federal governments will require some form of coordinated assessment.

The County brings a variety of resources to the work to prevent and end homelessness in the County, including political will, staff expertise, and funding.

Purpose

The purpose of the Centralized Access System (CAS) is to provide one centralized intake process for households to utilize when they believe they are at risk of becoming homeless, have a housing need, or they are currently deemed homeless according to HUD's definition. Via the CAS system a household can be screened for eligibility for specific housing options, including emergency shelter. The optimum goal of CAS is to assess a household, and then determine the best housing program that matches their unique needs.

Residency

Arlington County understands the difficulty and complexity of challenges faced by households experiencing homelessness; challenges that are compounded by living on the streets. Since Arlington County is geographically situated next to several nearby Virginia counties, across the bridge from Washington, DC and two Counties in Maryland, households may have difficulty documenting that they are current residents of Arlington County, VA.

However, the Arlington CoC CAS will serve households comprised of residents of Arlington County. The CoC recognizes that funding received from state and federal

sources may allow for services to be provided to residents of another jurisdiction. While meeting funding requirements, the Arlington CoC strives to provide services to all Arlington residents in need.

To process residency, Arlington County has established the following requirements below to demonstrate that a household is comprised of current Arlington residents.

For any household seeking **Eviction-Prevention services**, they must provide documentation of the following:

- **State ID (not expired):** An adult member(s) of a household should provide a copy of the current state issued ID that provides their name and the respective address at which the household adult members are currently residing.

- **Verified current Lease (within past 90 days):** An adult member(s) of a household should provide a copy of a lease from a property physically located in Arlington County. A copy of the lease should come directly from the leasing company to the Department of Human Services or be verified by CAS staff. The lease should contain the name of at least one adult person of the household and the other members of the household that resided at the location.

- **Documentation of Crisis:** Current 5 day Notice/Late (Must be notarized if from private landlord or not written on official letterhead, Court summons, or Notice or Writ of Eviction.

For households that are seeking to obtain **Emergency Shelter services**, family households must provide two (2) the following:

- **State ID (not expired):** An adult member(s) of a household should provide a copy of the current state issued ID that provides their name and the respective address at which the household adult members are currently residing.
- **Children enrolled in Arlington County School**: A family household should provide verification that their school aged children are currently enrolled in an Arlington County school. The children should have documented enrollment in school for 90 days prior to seeking emergency assistance. Worker must verify children's enrollment through APS Residency Specialist.
- **Verified current Lease (within past 90 days):** An adult member(s) of a household should provide a copy of a lease from a property physically located in Arlington County. A copy of the lease should come directly from the leasing company to the Department of Human Services. The lease should contain the name of at least one adult person of the household and the other members of the household that resided at the location.

- **Documented connection to local services:** An adult member(s) of the household should provide documentation that they are currently connected to an Arlington County homeless outreach provider (A-SPAN), or the Department of Human Services Treatment on Wheels Program for the past 90 days. The client

can also show documentation from their Behavioral Healthcare Division outpatient therapist that shows connection to services for the past 90 days if the therapist is able to verify where in Arlington they have been staying in order to receive services.

- **Temporary residents:** An adult member(s) of a household should provide a notarized letter indicating they have resided in Arlington County for the past 90 days. The letter should be notarized by an adult member(s) of the host household whose name is on the lease/currently owns the property and the adult member(s) of the household currently seeking assistance. A letter from a host that is the recipient of a housing subsidy (such as Section 8, Housing Grant, or Permanent Supportive Housing) will not be accepted as valid proof of applicant residency.

For homeless households currently **residing on the streets** and meeting the Federal definition of homelessness, the following guidelines will be utilized:

- **Meet the Standards of Residency:** When possible, the household should provide the above-mentioned information related to families (i.e. state ID) to be identified as an Arlington resident.

- **Inability to meet residency standards:** If the household is unable to provide one or more of the required proof of documentation, the household should be known to be living on the streets, parks, or other places not meant for human habitation (i.e. under a bridge) in the 26 sq. miles radius of Arlington County, participation as a resident of Arlington with A-SPAN (street outreach provider) for 90 days, or as a resident of Arlington active with the DHS Community Assistance Bureau , Treatment on Wheels (TOW) or Aging and Disability Services Division.

Special Note: Any household currently identifying themselves as an Arlington resident should not be receiving benefits in another jurisdiction.

Housing Options

Arlington County has a published goal to prevent homelessness whenever possible. The feasibility of maintenance of current housing or an assessment of housing options must be made prior to placing a household in emergency shelter. The County will provide emergency shelter for households with no other housing options. This practice will ensure that homelessness is prevented whenever possible and households with few or no options are placed in emergency shelter.

Through the intake process, the exploration of housing options is key and will serve as the primary component to avoiding shelter. Housing options are also imperative for quickly exiting shelter. Therefore, the Intake Specialist and case managers will focus on affordable housing options that include: subsidies from the Housing Grants program or

the Housing Choice Voucher program -*formerly Section 8* (when open), room rentals, and shared housing accommodations (living with relatives or friends).

Homeless Management Information System (HMIS)

Arlington County will utilize the Homeless Management Information System (HMIS) to collect data about households that are provided services in any program dedicated to serving the homeless, or households at risk of homelessness (prevention/diversion). The data obtained via HMIS will be utilized to help further guide and develop policy as it relates to Centralized Access and better inform the CoC of how programs designed for homeless households or households at risk of homelessness (prevention/diversion) are meeting the goals and objectives established at the federal, state, and local levels.

Progressive Engagement

Progressive engagement refers to a strategy of providing a small amount of assistance to everybody who enters your homelessness system, then waiting to see if that works. If it doesn't, you provide more assistance and wait to see if that works. If not, you apply even more, until eventually you provide your most intensive interventions to the few people who are left. Progressive Engagement has primarily been used in Rapid Re-Housing, but the principles apply to Prevention, Shelter, and Diversion services as well.

Progressive engagement requires a change in culture and at its core requires:

- Idea of doing the least for each household rather than the most
- Believing people can make it without us
- Empowering people to make it on their own

The progressive engagement model starts by offering a fairly basic level of assistance across the board. For example, a shelter might provide all households who enter with help preparing a housing plan, lists of units or landlords to contact , assistance preparing applications, and access to limited resources for fees and deposits or local transportation. For households unable to exit with this level of help, the program provides a greater level of housing search assistance, tied to short-term rental assistance and case management. For most households, this will be sufficient to stabilize in housing in the community within a fairly short period. If, however, the situation is still highly unstable after three or four months, the program can reassess the household and continue to provide assistance with the same or another resource, for the medium- or longer-term. Reassessment at this stage is frequent and assistance typically continued for a month at a time.

This approach is both responsive to the needs of the household while ensuring that interventions are right-sized to provide the greatest efficiency for the agency, and

the households assisted don't have to move, or even change programs or case managers along the way.

Gradual decline in assistance is one key component of Progressive Engagement. At any given time, the least amount of assistance is provided. This could mean that based on a client's resources, the program initially pays a large portion of the rent. However, based on change in resources or improved management of resources, over time the client is able to increase how much he/she can pay towards rent. As a result, the subsidy gradually declines and the program still provides the least amount of assistance needed.

Case Conferencing:

Families with ongoing housing needs are facing complex challenges. Often, comprehensive plans involving multiple stakeholders will yield the best outcomes. Case Conferencing is a collaborative approach to discussing the progress of households enrolled in any homeless services program who are having difficulty achieving service plan goals aimed at helping the household obtain or maintain stable housing. Families and individuals receiving shelter, diversion, prevention and/or rapid re-housing services can be involved in case conferencing.

When issues arise that involve client participation and/or adherence to program guidelines, the program staff should first work directly with the household to determine a plan to address the issues. Action steps for both the client participants and staff should be outlined. This plan should be in writing and specify S.M.A.R.T goals that are clearly explained to all participants. Once complete and signed, this plan should be sent to the Routing and Referral Manager in CCU. Reviews of progress should occur after 30 days.

Should there be a lack of significant progress, the program case worker should seek a case conference through DHS Clinical Coordination Program. An onsite case conference will be scheduled. During a case conference, a review of client participation will describe challenges and progress as well as outstanding areas of concern. Additionally, the meeting will include a review of current housing stability and if necessary future housing options. If amenable to continued participation with services, an updated service plan with objectives for the next 30 days will be created. If after this 30-day period, the household is still not compliant, the household may be discharged from the program.

Section II Centralized Access System (CAS)

Overview & Purpose

This policy and procedure manual will serve as the key source document detailing the CAS system. "Closing the Front Door" to homelessness is key to reducing new incidents of homelessness. The CAS system will provide a clear method in which persons at risk

of becoming homeless can be (1) assessed and (2) be determined eligible for housing programs within the Continuum of Care.

The CAS **WILL**:

- Assess households for their strengths and work with the clients in identifying needs
- Assess and screen households for **prevention services** (rental assistance and intensive case management services) and various housing options
- Assess and screen households for **diversion services, brief hotel placement, or shelter**
  Match households to programs based on their needs and information from assessment documents

The CAS **WILL NOT**:

- Create new housing in our system
- Guarantee a placement in a housing program or financial rental assistance

In addition to preventing homelessness, the CAS system will also serve as the access portal for households currently deemed as homeless and provide a path to housing options that include:

- Affordable Housing subsidy programs (i.e. Housing Grants, Housing Choice Voucher- when open);
- Alternative Living Arrangements (joint living arrangements, renting a room);
- Safe Haven programs;
- Transitional Housing programs;
- Rapid Re-Housing programs; and
- Permanent Supportive Housing programs.

The CAS system is a powerful tool designed to ensure that homeless persons and persons at risk of becoming homeless are matched, as quickly as possible, with the intervention that will most efficiently and effectively prevent or end their homelessness.

This policy and procedure manual has been developed based on the following priorities:

- A **uniform and standard assessment process** to be used for all those seeking housing assistance and procedures for determining the appropriate next level of assistance to resolve the homelessness of those admitted to shelter or other temporary housing accommodations;
- **Uniform written guidelines** among components of housing assistance (shelter, transitional housing and rapid re-housing) regarding: eligibility for services, priority populations to be served, expected outcomes and targets for length of stay;
- **Priorities for accessing prevention and homeless assistance** based on consumer need and assistance component type;

- **Referral policies and procedures** to guide the process from assessment of need to accessing assistance from homeless services providers;
- A **policies and procedure manual** detailing the operations of the CAS system.

The mission of the CAS system is:

To create a coordinated intake process that mutually empowers clients and providers to **effectively** and **efficiently** move clients to the best housing option for their individual needs.

Clients to be served

The CAS system will serve as the "front door" for households with critical housing needs that put the household at risk of becoming homeless and who may have barriers that prolong the episode of homelessness. The following clients are to be served:

- All households (individuals and families) in need who are residents of Arlington County;
- All households with a housing need (Prevention, Diversion, or Emergency shelter).

Arlington County will work with households to meet their housing needs that may include but not limited to: impaired decision making, disabilities that impair stability (e.g. mental health and/or substance abuse concerns), lack of natural supports, reluctance to provide information, legal issues (historical and pending), low-income or no income, medical issues, and other identified issues/concerns.

Procedures

The CAS will streamline access to programs that aide households at risk of becoming homeless or those households that are literally homeless within Arlington County. Programs include:

- **Prevention Services**
  - Short-term rental assistance (typically one-time assistance)
  - Medium-term rental assistance (includes case management)
  - Medium- to long-term rental assistance (includes case management)
- **Diversion Services**
- **Transitional Housing Services**
- **Rapid Re-Housing Services**
  - Short-term
  - Medium-term
  - Long-term
- **Hotel/Motel Services**
- **Emergency Shelter Services**

The **Clinical Coordination Program (CCP)** has First-Level Screening Authority for Prevention programs. This means Intake conducts initial screening, eligibility and service matching, while the receiving program (CCP Case Managers) makes final admissions decisions. For Rapid-Rehousing, most referrals come from the Shelters; the Intake Routing and Referral Manager reviews referrals, in consultation with DHS Homeless Services staff, and make suggestions on level of service recommended. The CAS Intake Unit, in consultation with the Diversion Specialist, has Final Admission Authority for all Shelter Services. Determination for each service will be made by CCP/CAS based upon the intake/assessment completed. Therefore, referrals for each program component, including CCP/CAS program services, will be made by CCP/CAS to the respective program. The referrals will take place via the HMIS system and additional conversations may take place by phone.

The level of authority is critically important as the CCP/CAS will be responsible for several aspects (e.g. Vacancy Tracking and Case Conferencing) of centralized intake. Therefore, it is imperative that CCP/CAS track placements and exits of households into and from programs to know the availability of program beds. Program providers will inform the CCP/CAS about future openings via an email or telephone call. Providers will provide as much lead time as possible for potential openings.

Prioritization standards for prevention, diversion, transitional housing, rapid re-housing, and emergency shelter have been established for each program component type. These standards will be consistent with the Guiding Principles outlined above.

Providers

The Department of Human Services (DHS) has partnered with a number of agencies that provide prevention services, emergency shelter, transitional housing, rapid-re-housing, and permanent supportive housing. Providers include:

- Bridges to Independence (formerly known as Bridges to Independence (B2I)
- Arlington Street People's Assistance Network (A-SPAN)
- Borromeo Housing
- Doorways for Women and Families
- New Hope Housing, Inc.
- Volunteers of America, Chesapeake
- Arlington DHS/CCP

Access to Services

The Arlington County CoC has chosen a single/centralized location model that will be available to households in crisis Monday through Friday from 8:00am to 5:00pm. Households can start the assessment process in two ways. Households can:

- Contact CCP/CAS by calling 703-228-1300 or 228-1010 to talk with a staff person between the hours mentioned above. Households will have to meet with an Intake and Diversion Specialist. Households that make a phone call first can also be informed of the appropriate documentation that will be needed in order to qualify for various programs within the Continuum of Care.

- Visit the CCP/CAS office at 2100 Washington Blvd, 1st Floor, Arlington, VA 22204 to be seen directly by an Intake Specialist. Upon arrival, the household will be assessed and informed of any additional supporting documentation needed to qualify for various programs within the Continuum of Care.

The CAS recognizes that households' emergencies may not take place during regular business hours. Emergency needs can arise after-hours, during holidays, and on weekends. To meet the needs of Arlington residents, the CAS system has established an emergency number that can connect households to a live person to discuss the nature of their emergency. A household experiencing a housing emergency after business hours, on weekends, or on County holidays can call 703-228-1010. (This line is also staffed during regular business hours by DHS staff.) The Emergency Line is staffed each month by one of four non-profit partners (A-SPAN, Bridges, Doorways, VOAC) that will conduct an interview, complete triage documentation, assess the household's emergency needs and make appropriate interventions. The household may be asked to come to an alternate location when determined necessary by the staff conducting the assessment. If on-call staff has an issue resolving a call, they should consult/notify their on-call supervisor. At the conclusion of an intake, the trained intake staff will:

- Complete intake paperwork via the HMIS System;

- Make a referral to the CCP/CAS if the household has a housing crisis and is in need of services from the County.

Screening/ Assessment

The CCP/CAS is the main entity responsible for ensuring that all households experiencing homelessness and at-risk of homelessness are promptly screened and assessed. It is anticipated that most requests and screening will take place via the CCP/CAS Monday through Friday from 8am to 5pm.

CCP/CAS intake staff will complete intake in the community at the jail, hospital, etc if after consultation with the referring partner it is agreed that the client would not be able to make it in on their own. This includes, but is not limited to, clients that are mandated by the magistrate/judge to go "bed to bed" from jail to shelter or clients who are too ill to come in on their own. CCP/CAS may also complete intake assessments over the phone when a client is in isolation or quarantined (ex. A client with active TB, or who is in recovery for another illness).

When a household presents with a housing crisis (i.e., a household is identified as literally homeless or at imminent risk of homelessness), the following steps will be taken:

- **Complete Intake Assessment:** One (1) of four (5) Intake Specialists will assess the household's needs and identify the appropriate level of housing or support needed. Households will be required to provide supporting documentation per program requirements (See documentation under this section).
- **Diversion:** If diversion is identified as a viable option to shelter, the household will meet with the Diversion Specialist to explore: (1) if the current housing can be successfully maintained or (2) if another housing options (e.g. living with relative, friends, family) is plausible.
- **Emergency Shelter: If the household cannot be diverted form shelter,** a referral for emergency shelter will be made to one of the four emergency shelter providers for all households meeting the HUD definition of homelessness and with no other viable housing options. Once a household is admitted to an emergency shelter that provider will:
    - **Complete the Shelter Intake Form**
    - **Complete the SPDAT**:

The County and partners of an Assessment Entity will have trained staff to complete the required Triage form, and the F-SPDATs after hours (5:00pm to 8:00am) and on weekends & holidays. Partnering Agencies will serve as an Assessment Entity after County business hours, on weekends, and on County holidays. Partnering Agencies will triage 1010 calls and refer households to CCP/CAS for service the next business day. In cases where there is a true emergency and need for shelter service, a household will be referred to the appropriate shelter, if there is an opening. This is considered a temporary solution until a full screening is conducted by CAS.

Entities and individuals that complete assessments must meet the responsibilities of an Assessment Entity, which include:

- submission of assessment forms to the CAS
- responding to requests by CAS for clarifying information
- client notification of eligibility and referral decisions
- participation in case conferences
- informing clients of appeal process

Documentation

There are several forms of documentation that could be requested from a household to complete the assessment to access prevention and supportive services connected to permanent housing.

All households will provide the following:

- Proof of Arlington County residency. (see earlier document requirements)
- Proof of Income (e.g. paystubs, SSI or Social Security letter indicating receipt of benefit, Child support verification, etc.).
- Documentation of assets (401K, recent bank statements, etc.).

Households seeking prevention assistance must additionally provide:

- Proof of being at risk of becoming homeless (i.e. Eviction notice from Court, 5 Day Pay or Quit, Late Notice).
- Copy of current lease

Households seeking or who will be provided access to emergency shelter, diversion services, and/or rapid re-housing must provide:

- Proof of Homelessness (letter from current provider, or information gathered from the HMIS system).
- Documentation of imminent eviction from housing.

Vacancy Tracking

The Clinical Coordination Program/CAS will manage a centralized vacancy tracking system for all of the following programs:

- Prevention;
- Diversion;
- Transitional Housing/other Permanent Housing;
- Rapid Re-housing;
- Hotel/Motel Assistance; and
- Emergency Shelter

The CCP/CAS will track all beds designated to serve households at risk of becoming homeless and households deemed literally homeless. Referrals will be made to appropriate vacant beds and program slots when available.

To the extent possible, the CCP/CAS will use HMIS to manage the vacancy tracking system. Programs will be required to post vacancies in homeless designated beds in HMIS within eight (8) hours of unit/bed availability. If providers know of an impending vacancy, they will be required to post the anticipated availability date within two (2) business days of being made aware of such availability and updating HMIS with the actual availability date once the bed becomes vacant. Programs must update vacancy information in HMIS within eight (8) hours of a unit/bed being filled.

Prioritization

Prioritization standards have been established for each program component of the CAS System. All households will be assessed accordingly and determined if eligible for programs that prevent homelessness which include:

- Prevention eviction services;
- Diversion services;
- Transitional housing; and
- Rapid Re-housing

Households that are currently homeless will be assessed to determine if they are eligible for permanent housing programs that include:

- Rapid re-housing;
- Subsidized housing (Housing Grants, Housing choice voucher- when open)
- Permanent Supportive Housing
- Shared Housing

Referrals

CCP/Intake has different authority for referral decision for different programs. See page 11 for explanation. Eligibility for all programs will be determined by CCP/CAS per standards set by COC partners and be based upon the intake/assessment completed. Therefore, referrals for each program component will be made by CCP to the respective program. The referrals will take place via the HMIS system and additional conversations will take place by phone.

Homeless programs may only accept clients into their programs (Diversion, Prevention, Emergency Shelter, Rapid Re-Housing) based on referral made or review completed by the CCP/CAS. No provider may admit households to beds designated for literally homeless people unless referred/reviewed by the CCP/CAS.

Section III Prevention

Overview & Purpose

When applicants seek to maintain their existing housing (i.e. a valid leased apartment, a valid sub-lease or room rentals with a valid lease), the CAS process will assess the household and determine the appropriate level of progressive engagement. Progressive engagement is determined by defining the amount or level of assistance and/or supportive services a household will receive using the specific progressive engagement approach.

Through the CAS process, in conjunction with the household, a minimum amount and duration of assistance needed to achieve housing stability will be recommended. If it becomes clear at a later date that the amount and/or duration are not enough, the household will be reassessed, and the amount and duration of assistance may be adjusted with authorization from Arlington County CAB Bureau Chief. Each participating household must be recertified at three month intervals throughout their program participation. The guiding principal for all Prevention funds is: If not for the financial assistance intervention, the household would be literally homeless.

Arlington County has three (3) categories of prevention assistance to meet the needs of households at risk of becoming homeless. Please reference Section III for specific policies and procedures concerning Prevention Services.

Table 1 – Prevention Assistance Program Types

Category 1	**Short-Term/One-Time Rental Assistance**	Designed for households in which a temporary set-back occurred (i.e. temporary injury, loss of hours) and this setback has placed the household at risk of becoming homeless. Assistance will maintain the household's current permanent housing. **Length of Time:** One (1) to two (2) months of financial services. Worker will verify if at the end of the assistance the client will return to work or regain income and can maintain housing. Most households would need a maximum of two months assistance.
Category 2	**Medium Term Rental Assistance**	Program is designed to assist households that appear to need three or more months of rental assistance. The barriers (e.g. poor money management, low income/wages, under-employment) the household presents with require financial assistance coupled with case management stabilization services. **Length of time:** Three (3) to six (6) months of overall assistance. The financial assistance can cover a

		portion of rent. The determination of how the financial assistance is provided depends on Individual Service Plan (ISP) drafted by the case manager and household. Households pay 30-40% of their said income towards rent. The rent assistance can be step down in nature (gradual decrease in the amount of funding provided over a period of time).
Category 3	**Intensive Case Management Services**	Program is designed to assist households that appear to need intensive case management services in the home. Financial assistance exceeds eight months. The barriers (e.g. poor money management, low to no income/wages) are extensive and may have more than one critical barrier. **Length of time:** seven (7) to ten (10) months of overall assistance. The financial assistance can cover a portion of rent. The determination of how the financial assistance is provided depends on the on Individual Service Plan (ISP) drafted by the case manager and household. Households pay 30-40% of their said income towards rent. The rent assistance can be step down in nature (gradual decrease in the amount of funding provided over a period of time).

Clients accessing Prevention Services

Prevention services are designed to work with households that after, completion of the intake paperwork, demonstrate they are clearly at risk of becoming homeless if assistance is not provided to the household. The level of services provided to a household will be based on the **intake assessment**.

Procedures

To access Prevention Services the following procedures will be followed:

- An Intake Specialist will complete the **Intake Interview and Assessment**. If upon completing the assessment, it appears that the household is in need of prevention services that will allow the household to maintain housing, the documents will be uploaded into HMIS.
- All cases are routed through the Referral and Routing Manager (RRM) to be distributed among all case managers.
- The Partnering Agency or CCP Case Manager will review the referral request and clarify questions with the Intake Specialist.
- The assigned case manager will contact the household within 24 hours to begin any additional assessments and develop a service plan for the household.

CCP/CAS

Providers

Prevention Services can be provided by the following:

- Arlington County Government/CCP (Short-term, Medium-term rental assistance & Intensive Case management & Housing Focused Case Management)
- ASPAN (Housing Focused Case Management, Financial Counseling)
- Volunteers of America, Chesapeake (Housing Focused Case Management, Financial Counseling)

Screening/Assessment

The CCP/CAS is the main entity responsible for ensuring that all households at-risk of becoming homeless are promptly screened and assessed. When a household presents with a crisis (i.e., Impending Court Eviction, Late Notice, 5 Day Pay or Quit), the following steps will be taken:

- **Intake Interview and Assessment:** One (1) of four (5) Intake Specialists will ascertain the household's needs and identify the appropriate level of prevention. Households will be required to provide supporting documentation with respect to their need for assistance (See documentation under this section).
- **Prevention Services:** For households that appear to be eligible for prevention services, the Intake Specialist will complete the necessary paperwork and gather supporting documentation to begin the referral process.

Documentation

All households will provide the following:

- Proof of Arlington County residency.
- Proof of Income (i.e. paystubs, SSI or SSA letter indicating receipt of benefit, Child support verification, etc.).
- Documentation of assets (401K, recent bank Statements, etc.).
- Proof of being at risk of becoming homeless (i.e. Eviction notice from Court, 5 Day Pay or Quit, Late Notice).
- Copy of current lease (special note: the Intake Specialist will contact the landlord/property management to verify the lease).

Financial Resource Tracking

The CCP/CAS will monitor expenditure of financial assistance by program in order to assess availability of resources on an on-going basis and to prevent unexpected or rapid depletion of resources. This tracking will also detect when funds are being spent too

slowly. Quarterly meetings will be held with all Partnering Agencies to review program and financial data.

Prioritization

There are no identified priority populations with respect to Prevention Services. The main purpose to assess and determine what is the next best course of action to assist a household in maintaining their existing housing.

Referrals

The level of authority for all the above-mentioned programs will be exercised by CCP/CAS. Determination for Prevention Services will be made by CCP/CAS based upon the Intake Interview and Assessment -. Therefore, referrals for this program component will be made by CCP to the respective program. The referrals will take place via the HMIS system and additional conversations will take place by phone. The CCP/CAS will make the referral through HMIS indicating the need for prevention services to the appropriate agency. CCP/CASService programs may only accept clients into their programs based on referrals made by the CCP/CAS.

Re-certifications

Households receiving Prevention assistance must be recertified every three months for program eligibility. Such reviews will determine if the household meets income guidelines and still needs program assistance. Assistance beyond each recertification should be provided per progressive engagement guidelines and clearly conveyed to household. If household no longer meets program eligibility at time of re-certification, case management should provide referrals to other services if needed and follow procedures to close case.

Program Acceptance Notification

All households accepted to Prevention services must be provided a program acceptance letter noting the case management information, program entry date and relevant assistance priorities.

Termination/Grievance

Any individuals seeking and/or receiving prevention assistance must receive written notification of the agency's grievance policy. Grievance policies must provide specific procedures to be followed for any disputed prevention program decision impacting the participant's financial assistance.

The agency may terminate assistance to a program participant who violates program requirements. Agencies may resume assistance to a program participant whose

assistance was previously terminated. In terminating assistance to a program participant, the agency must provide: (1) Written notice to the program participant containing a clear statement of the reasons for termination; (2) A review of the decision, in which the program participant is given the opportunity to present written or oral objections before a person other than the person (or a subordinate of that person) who made or approved the termination decision; and (3) Prompt written notice of the final decision to the program participant.

Closure Notification

All households being closed to program services- regardless of reason, must be provided a program closure letter noting the exact closure date, reasons for closure and grievance policy related to case closure.

Section IV Housing Location Services

Overview & Purpose

Arlington County has implemented a best practice model called Housing Location Services which is an integral component of the Centralized Access System. Housing Location services, can help households in three specific ways:

- **Barriers to Housing:** For households that have one or several barriers to housing (e.g. poor credit, criminal history, poor or no rental history), the housing locator will work with the client, the referring party, and potential landlords to identify housing options within the County.

- **Housing negotiation:** When some households seek eviction prevention services, it may be necessary for the Housing Locator to talk to the property manager/landlord on behalf of the households to determine if there is a possibility of remaining in the housing.

- **Housing Inspections**- the Housing Locator will perform Lead Paint and Habitability inspections.

Housing location services are specifically designed to assist households that have demonstrated an inability to secure their own permanent housing. This also includes households that have applied and been denied for housing within the past six months.

In summary, the housing locator has an important role to help prevent persons from becoming homeless; another goal is to identify a viable housing option for the households with barriers.

Clients to be served

Housing location services are designed to work with households that, after completion of the intake paperwork, demonstrate that there are barriers to securing or maintaining their existing housing. In most cases the household has been denied access to housing (e.g. lease for an apartment) within the past six-month period.

The requests for Housing Location Services will be based on the **Intake Interview and Assessment** completed by an Intake Specialist. The need for the service will be indicated on the **Housing Locator Referral Form which is emailed to the Housing Locator**.

Procedures

To access housing location services the following procedures will be followed:

- An Intake Specialist will complete the **Intake Interview and Assessment**. If it appears that the in the Triage form.
- The Case Manager completes the **Housing Location Referral Form and sends it to the Housing Locator via email.**
- The Housing Locator reviews the referral request and clarifies questions with the Case Manager.
- The Housing Locator then works with the on-going case management services and the Intake Specialist, if necessary, to identify the most appropriate housing option.
- The Housing Locator will send to the on-going case manager, rental unit opportunities that address the household's barriers.
- Households will follow up with landlords within 24 hours of being informed of the rental opportunity.
- Should there be a need for additional assistance, the on-going case manager can have a case conference with the Housing Locator.
- The Housing Locator will conduct all applicable inspections if a client is approved for tenancy.

Provider

Currently, the ASPAN housing locator is designated to provide Housing Location Services to clients receiving Prevention Services.

Screening/Assessment

Households eligible for services from the Housing Locator will be screened and identified by the Intake Specialists. The on-going Case Manager will process the referral for housing locations services.

Documentation

To better serve households referred for Housing Location services, the Housing Locator may request additional information that will link households with the most appropriate housing option (i.e. Property Management Company). These documents may include:

- Credit Report
- Criminal History if applicable

Referrals

All referrals for housing locations services will originate from the CCP/CAS via one of four Case Managers.

Section V Diversion

Overview & Purposes

Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to or keep their existing permanent housing. Diversion services will play a critical role in reducing the number of households entering emergency shelter for single adults and families with children. Diversion programs can:

- Reduce the number of families becoming homeless;
- Reduce the demand for shelter beds; and
- Eliminate the need for program wait lists.

Diversion programs can also help the Arlington community achieve better outcomes and be more competitive when applying for federal funding.

Any household seeking access to emergency shelter services will be assessed to determine if the household can be diverted from shelter. Diversion services will be located within the Assessment Center that is operated by the Clinical Coordination Program (responsible for conducting initial intakes for households).

All households seeking shelter or at imminent risk of homelessness will meet with the Intake Specialists who will then make referral to the Diversion Specialist for diversion

services if necessary. The Diversion Specialist will be responsible for providing case management services (including service planning) and coordinating the services with natural supports (family, friends, faith based organizations, etc.). Please reference Section V for specific policies and procedures concerning Diversion Services.

Client to be served

Within Arlington County, any household (individual or family) seeking to access emergency shelter will be eligible to meet with the Intake Specialists who determine if diversion services are appropriate. National statistics state that approximately 25% of households seeking emergency shelter can be diverted.

Procedures

To access Diversion Services the following procedures will be followed:

- An Intake Specialist will complete the **Intake Interview and Assessment**.
- If upon completing the assessment, it appears that the household may benefit from Diversion Services that will allow the household to maintain their existing housing or extend their housing stay until additional housing can be accessed:
    - The Intake Specialist will submit a referral request for services to the Diversion Specialist via the HMIS System.
- The Diversion Specialist will review the referral request and clarify questions with the Intake Specialist.
- The Diversion Specialist will work with the household to identify housing options to include family, friends, co-workers, and other natural supports.
- The Diversion Specialist will complete any additional assessment, develop a service plan and be responsible for monitoring the progress of the established service plan.
- If single individuals or families referred to shelter do not follow through with their service plan, the Diversion Specialist will follow up with the client. If the client does not engage the case will be closed after 30 days of no contact. Case notes will be maintained in HMIS.

Providers

There are two distinct providers that work in collaboration with one another to provide diversion services to households. The providers are as follows:

- Arlington County Government (Intake & Assessment)
- Volunteers of America, Chesapeake (Diversion Services)

Screening/Assessment

The **Intake Interview and Assessment** explores possible housing options to avoid shelter entry and assesses the type of intervention that is most appropriate to meet a household's immediate and long-term housing needs. Trained staff person may conduct the **Intake Interview and Assessment**. These households must be assessed via the CCP/CAS.

CCP/CAS

Documentation

Documentation of Arlington County residency and meeting the definition of homelessness are the two major criteria of program eligibility and therefore need documentation noted earlier.

Prioritization

The priority populations for Diversion services are those who, with staff support, can be diverted from entering the emergency shelter system by exploring other alternatives of housing (temporary and permanent) that can be maintained or located.

The main goal is to appropriately assess and identify households that can be prevented from entering shelter.

Referrals

All referrals for Diversion Services will originate from the CCP/CAS via one (1) of four (5) Intake Specialists. At a minimum the Intake Specialist has completed the **Intake Interview and Assessment** which documented a need for the services.

Section VI Rapid Re-Housing

Overview and Purposes

Based on national research and best practices, Arlington County has committed to investing funds in rapid re-housing short term rental assistance for homeless families in Arlington County. Rapid re-housing is a set of strategies that permanently houses individuals and families as quickly as possible with a level and duration of support that is tailored to meet the needs of each household. Each household has a lease in their name and is connected to mainstream self-sufficiency services in the community. Providers are expected to remain engaged with the households from first contact to program exit, using a progressive engagement approach and tailoring services to the needs of the household in order to assist the household to maintain permanent housing. Additionally, providers

will engage in efforts to reconnect with households after they exit from the program in order to determine housing stability beyond short-term subsidies.

Arlington County has implemented the following Best-Practice Rapid Re-Housing Strategies:

- Moderate-term Rental assistance
- Flexible funding for security, utility deposits
- Home-based Case management to help access needed services to move to self-sufficiency
    - Employment Services
    - Budgeting
    - Public Benefits such as child care, SNAP, tax credits, Medicaid, and TANF)
- An organized housing search strategy including landlord mediation

Families must be able to live independently and not need assistance with everyday tasks. They must also sign a program agreement that details their responsibilities as a tenant and participant in the program, including agreeing to meet with a case manager at least once per month, and agree to be entered in the HMIS system, unless exempt as a victim of domestic violence.

The program agreement does not mandate participation in any of the services offered by a rapid re-housing provider. The program does not require families to be employed; however, they must be willing to work toward increasing their self-sufficiency so they can pay for housing when the time-limited subsidy ends.

Rental assistance payments are not made to program participants, but only to third parties, such as landlords. In addition, an assisted property may not be owned by the grantee or the parent, subsidiary or affiliated organization of the grantee. No staff participating in these programs may benefit from them.

Rapid re-housing assistance requires that the program participant head of household have the valid lease that is in compliance with tenant/landlord laws in their name. A copy of this lease must be included in the program participant record.

Partnering agencies must have written agreements with both the program participant and the landlord that identify the terms of the rapid re-housing assistance. This should specifically provide the landlord with guidance for addressing issues which could impact housing stability.

Clients to be served

The Rapid Re-Housing program targets Arlington individuals and families who are homeless. These include the following households:

1. Individuals and families who lack a fixed, regular, and adequate nighttime residence including those residing in a shelter or a place not meant for human habitation and those exiting an institution where they resided temporarily.
2. Individuals and families who will imminently lose their primary nighttime residence
3. Unaccompanied youth under 25 years of age, who have not had a lease and have moved 2 or more times in the past 60 days and are likely to remain unstable because of special needs or barriers.
4. Individuals and families who are fleeing or attempting to flee domestic violence

Priority Populations

Please reference the Table 2 below.

Table 2 – Categories of Homelessness that Qualify for Rapid Re-Housing

Category 1	**Literally Homeless**	Includes those households who are literally homeless and includes those households living temporarily in a hotel/motel being paid for by limited local, state, or federal funded assistance. It also includes individuals exiting institutions where they resided temporarily. In these cases, the institution's discharge planning has resulted in no identified resources (including homeless prevention assistance) and the individual has no other resources. In all cases, these households are eligible for shelter services and rapid re-housing. Regardless of the intervention employed a housing barrier assessment (Full SPDAT) must be completed at program entry with an immediate focus on housing stabilization.
Category 2	**Imminent Homelessness**	Includes those households who are currently housed whether in their own unit or living in someone else's unit. These households must be screened immediately for prevention assistance eligibility. All household's eligible for prevention assistance must be diverted where possible from shelter. Partnering agencies must work with centralized access system (CAS) and homeless prevention providers to identify and divert all appropriate households. Where shelter assistance cannot be avoided a housing barrier assessment must be completed at program entry with an immediate focus on housing stabilization.
Category 3	**Homeless under other Federal Statutes**	Homeless Under Other Statutes Unaccompanied youth under 25 years of age, or families with children and youth, who do not meet any of the other categories but are homeless under other federal statutes, have not had a lease and have moved 2 or

		more times in the past 60 days and are likely to remain unstable because of special needs or barriers.
Category 4	**Fleeing Domestic Violence**	Includes households fleeing or attempting to flee a domestic violence or other physically threatening living situation. These households must be screened, where possible, immediately for prevention assistance eligibility. All households screened for assistance will be diverted where possible. Partnering agencies must work, with centralized access system and homeless prevention providers to identify and divert all appropriate households. These households are eligible for shelter and repaid re-housing assistance. Regardless of intervention employed a housing barrier assessment must be completed at program entry with an immediate focus on housing stabilization.

Re-housing assistance beyond three months requires recertification of eligibility. This recertification must be completed every three months.

Re-certifications:

State Program Recertification requires agency certification and evidence of:

- Program participant household income below 30 percent area median income (AMI)
- The household lacks the financial resources and support networks needed to remain in existing housing without rapid re-housing assistance
- Housing stabilization services are being appropriately implemented
- Household has no more than $500 in assets (includes all checking, savings, retirement accounts, a second vehicle, stocks, bonds, mutual funds, and real estate). This does not include primary, appropriate, and reasonable transportation, pension or retirement funds that cannot be accessed.

While income eligibility is not required when households first access rapid re-housing because they are literally homeless, it is required when recertifying to show continued need for rapid re-housing assistance.

Grantees should use HUD's Section 8 income eligibility standards for Rapid Re-Housing programs.
Income limits are available on HUD's web site at: http://www.huduser.org/DATASETS/il.html.

Procedures

To access Rapid Re-Housing Services the following procedures will be followed:

- For homeless households in shelter, the shelter case manager will use the SPDAT as a guide to determine the best housing approach for the household. If after completing the SPDAT, the household is determined an appropriate fit for RRH, the case manager will refer the household via RRM for a RRH conference.
    - This referral will take place regardless of whether the respective agency has RRH space within their organization- as the household can enter RRH in any program within the continuum.
- After consultation with the household regarding the tenets of RRH, the shelter case manager will electronically forward the household's Brief Triage Form to the RRM. The Triage form must contain a synopsis of the household demographics, strengths and barriers.
- The RRM will schedule a RRH conference to include all necessary staff from the referring organization as well as DHS staff. This meeting will take place within 1 week of the referral if possible.
- The case conference will be a discussion between the various organizations. The purpose will be for the referring agency to clarify information provided on the Brief Triage Form and to their plan for RRH. .
- Upon completion of the case conference, the RRM- in consultation with HAB Homeless Services representative- will document the plan and recommendations (if any) for the household and record the conference outcome in HMIS.
- The RRH program will update DHS of any issues related to the referral in a timely manner.
- The Partnering Agency will keep the CCP/CAS Supervisor informed should the household neglect to follow through or meet on the scheduled basis agreed upon.

Providers

Four distinct providers provide the various levels of rapid re-housing services to households. The providers are as follows:

- Arlington County Government (Administrative oversight, assessment, and referral services)
- Bridges to Independence (Rapid Re-Housing for Families)
- Arlington Street People's Assistance Network (Rapid Re-Housing for Single Adults)
- Doorways for Women & Families Rapid Re-Housing (Rapid Re-Housing for Families)

Note: All programs will accept eligible couples to the extent funding sources permit and space is available.

Screening/Assessment

To be eligible for Rapid Re-Housing a household must meet the HUD definition of being homeless described in Table 2. Households that have been screened and determined to eligible to receive Rapid Re-Housing, will be informed about the level of assistance that will be provided. Reference Table 3 below regarding the varying levels of services to be provided.

Table 3 - Type of Rapid Re-Housing Assistance

Level 1	**Short-Term Rental Assistance**	Household will need minimal assistance to obtain and retain housing. • Housing search assistance • Financial Assistance for housing start-up (e.g. first month's rent, security deposit, utility deposit • Time-limited rental assistance, per client housing plan • Home visits after move-in • Offer of services for up to 3 months **Length of time: up to 3 months**
Level 2	**Medium Term Rental Assistance**	Household will need routine assistance to obtain and retain housing. • Housing search assistance • Financial assistance for housing start-up • Time limited rental assistance, per client housing plan • Weekly home visits for first two months, then reduce to bi-weekly or monthly as most housing plan goals are met • Services available for up to 6 months, depending on housing issues and progress toward housing goals **Length of time: up to 6 months** The determination of how the financial assistance is provided is guided by the recommendations of the CAS RRM and the on-going work with the case management services. Households pay 30-40% of their said income towards rent. The rent assistance can be step down in nature (gradual decrease in the amount of funding provided over a period of time).

Level 3	**Medium-long Rental Assistance**	The household will need more intensive and/or longer assistance to obtain and retain housing. • Housing search assistance • Financial assistance for housing start-up • Time-limited rental assistance, per client housing plan • Ongoing housing focused case management • Weekly home visits for first two months, then reduce to bi-weekly or monthly as most housing plan goals are met. Unannounced drop-in visits to be considered by case manager • Services available for up to 9 months, depending on the housing issues and progress toward housing goals **Length of time: up to 9 months** Program is designed to assist households that appear to need intensive case management services in the home coupled with financial assistance. The barriers (i.e. poor money management, low income wages) are extensive and may have more than one barrier critical barrier. The determination of how the financial assistance is provided is guided by the recommendations of the CAS intake RRM and the on-going work with the case management services. Households pay 30-40% of their said income towards rent. The rent assistance can be step down in nature (gradual decrease in the amount of funding provided over a period of time).
Level 4	**Long-term rental assistance**	Household will need intensive and longer assistance to obtain and retain housing • Housing search assistance • Financial assistance for housing start-up • Time-limited rental assistance, per client housing plan • Ongoing housing focused case management • Weekly home visits for first two months, then reduce to bi-weekly or monthly as most housing plan goals are met. Unannounced drop-in visits to be considered by case manager • Services available for 12-18 months with extensions after case conferences, depending

		on the housing issues and progress toward housing goals **Length of time: 12-18 months** Program is designed to assist households that appear to need intensive case manage services in the home coupled with financial assistance. The barriers (i.e. poor money management, low income wages) are extensive and may have more than one barrier critical barrier. The determination of how the financial assistance is provided is guided by the recommendations of the CAS intake and the on-going work with the case management services. Households pay 30-40% of their said income towards rent. The rent assistance can be step down in nature (gradual decrease in the amount of funding provided over a period of time).
Level 5	**Long-Maximum financial assistance**	Household needs longer or more intensive services; may need staff with more professional training. • Housing search assistance • Financial assistance for housing start-up • Rental assistance, per client housing plan • Ongoing housing focused case management • Weekly home visits for first two months, then reduce to bi-weekly or monthly as most housing plan goals are met. Unannounced drop-in visits to be considered by case manager • Services available for up to 24 months, depending on the housing issues and progress toward housing goals **Length of time: 18-24 months**

Documentation

To be eligible for RRH, households must provide proof of the following**:**

- Proof of Arlington residency
- Proof of Income (if applicable)
- Proof of Homelessness
- Proof of assets, if applicable (401K, recent bank statements, etc.)

Vacancy Tracking

To the extent possible, the CCP/AC will use HMIS to manage the vacancy tracking system. Programs will be required to post vacancies in homeless designated beds in HMIS within eight (8) hours of unit/bed availability. If providers know of an impending vacancy, they will be required to post the anticipated availability date within two (2) business days of being made aware of such availability and updating HMIS with the actual availability date once the bed becomes vacant. Programs must update vacancy information in HMIS within eight (8) hours of a unit/bed being filled. Exceptions to HMIS requirements and related processes for referrals to and from other systems not using HMIS will be defined in the Policies and Procedures Manual.

Prioritization

The Arlington County Continuum of Care has established the following priority populations for all Rapid Re-housing programs. Households that fall into the following categories rank highest in priority for this housing strategy.

1. Families with children with greatest service need;
2. Youth- aged 18-24;
3. Veterans (regardless of discharge status).
4. Households without income.

The Strategy shall incorporate a lower barrier, Housing First model. This means households do not have participation requirements or pre-conditions to entry, such as sobriety or minimum income threshold, and prioritizes rapid placement and stabilization in permanent housing.

Terms of Assistance

Rental assistance is tenant-based rental assistance that can be used to allow individuals and families to obtain and remain in rental units.

- No program participant may receive more than 24 consecutive months of assistance (including any rent arrears).
- Agencies must provide the appropriate level of case management in order to assure housing stability on leaving the program.
- Participants may be required to share in the costs of rent.

A hallmark of Arlington's Rapid Re-Housing programs is the level of flexibility provided in how households are provided a broad range of rental assistance program design options that include:

- **Income□based Subsidy**: Under an income□based model, a household pays a specific percentage of its income towards rent and utilities (e.g. 30 percent, 40 percent, and 50 percent).

- **Graduated/Declining Subsidy:** The subsidy would decline in "steps" based upon a fixed timeline or when the individual has reached specific goals, until the household assumes full responsibility for monthly housing costs. The steps are known in advance and act as deadlines for increasing income.

- **Bridge Subsidy:** A bridge subsidy provides temporary assistance for individuals to help them obtain/maintain housing until a longer□term or even permanent subsidy becomes available. Bridge subsidies are often used for persons who have severe housing barriers and are on waiting lists for other long□term subsidies.

When partnering agencies are utilizing the income-base subsidy, the household's rent should be calculated using HUD's **Rent Calculation Form** to determine the portion of the households rent to be paid.

When households are preparing to transition to a Housing Grant and have applied clients and/or case managers shall request of the Housing Grant Program an Estimate Letter. Estimate Letters are not just intended for homeless clients prior to move-in, but are essential to existing RRH clients that will transition to the Housing Grant. The letter will help RRH staff plan with the household by appropriately increasing the subsidy in preparation for Housing Grant. Additionally, if a household's income increases or decreases significantly during the Housing Grant application process, an updated estimate letter can be requested to ensure that the household has accurate knowledge of the approaching subsidy.

Referrals

- Most referrals for Rapid Re-housing are initiated by the Shelters. An official RRH conference must take place prior to households accessing RRH. Households shall not be housed with RRH funds prior to this conference.

Process for RRH entry:

- The referring worker completes the referral in HMIS including submission of required supplemental attachments:

    - Triage Form
    - CAS Conference Request Form
    - The CAS Routing and Referral Manager reviews referrals and schedules the Rapid Re-Housing Conference within 10 business days. This conference includes DHS Homeless Program staff, the referring entity, the intake entity (if different) Referring workers must be able to answer all of the RRH Intake Questions that are provided on the CAS Conference Request Form during the RRH Conference.
- During the RRH conference discussion points include: level of assistance recommended, type of subsidy (see Table 3), household strengths and barriers, and additional supports recommended.

Termination

Any individual seeking and/or receiving rapid-rehousing assistance must receive written notification of the agency's grievance policy. Grievance policies must provide specific procedures to be followed for any disputed rapid re-housing program decision impacting the participant's financial assistance.

The agency may terminate assistance to a program participant who violates program requirements only after written notice of corrective action has been given to household and a DHS case conference has convened. In terminating assistance to a program participant, the agency must: (1) Provide written notice to the program participant containing a clear statement of the reasons for violation/termination; (2) Provide review of the decision, in which the program participant is given the opportunity to present written or oral objections before a person other than the person (or a subordinate of that person) who made or approved the termination decision, (3) Request and Attend a DHS case conference if issues are not resolved; and (4) Provide prompt written notice of the final decision to the program participant. Aforementioned documentation must also be submitted to DHS RRM.

HMIS Reporting

Rapid Re-Housing agencies are required to report program participant-level data, such as the number of persons served, demographic information and financial assistance provided in the Homeless Management Information System (HMIS) database.

Please note that domestic violence assistance providers may, in lieu of HMIS, use a comparable system. Such providers are responsible for meeting all HMIS data standards and reporting requirements regardless of the data collection system utilized.

Note: CCP/CAS now tracks DV households anonymously in HMIS.

Outcome Measures

Partnering agencies should meet the outcome measures established in the CoC Report Card as well as the outcomes measures established by the State.

Housing Location

When households are moved into a new unit. The rent must meet two standards:

- Rent Reasonableness – rent is equal to or less than other like units in the area.
- Fair Market Rent (FMR) – rent (including utilities) is at or below the HUD established FMR for the unit size in the area.

Housing Quality Standards

All units that a participant moves into must be deemed habitable and conform to the County code. A Habitability Standards form must be completed and included in program participant records in all applicable cases.

Lead Based Paint

Housing that is occupied by families with children and that was constructed before 1978 - must also comply with Lead Based Paint inspection requirements, per the Lead Based Paint Poisoning Prevention Act. A Lead-Based Paint Visual Assessment form must be completed and included in program participant records in all applicable cases.

Re-Housing Standard Timeframe

Clients receive 3 to up to 18 months of assistance in rapid re-housing. On a case by case basis and with approval obtained through a case conference, a household can be served up to 24 months.

At reassessment, some clients graduate if they are ready to be on their own, others who need continued assistance go month to month with assistance and continue to be recertified at three month increments.

Landlord Marketing

Successful marketing efforts often utilize the following selling points to explain the "win-win" for landlords in partnering with social service programs:

- Households are provided individualized case management before and after the move, including tenant education, budgeting, household management, employment assistance, and crisis intervention.
- Services are often provided on-site through regular home visits (often for a transitional period of time, e.g. 3-6 months).
- Landlords have access to dedicated point persons responsive to their concerns and needs, and can expect prompt intervention with tenants when requested.
- Program participants and sometimes other tenants in the same buildings – have access to, or can be linked to, intervention programs to address issues or crises (e.g., rent-to-prevent eviction assistance).
- Double security deposits can be paid on behalf of tenants

Section VII Permanent Supportive Housing

Overview and Purposes

Based on national research, Arlington County has committed to utilizing funds to operate the best practice model of Permanent Supportive Housing Programs (PSH) for persons identified as chronically homeless. All Co C Permanent Supportive Housing Programs utilize a "Housing First" model which means that households are moved into housing despite barriers to accessing housing (i.e. criminal history, poor credit, etc.) and no requirements are placed on the household to access the program. The CoC's PSH programs are designed to provide a rental subsidy (typically 30% of the household's income) and the supportive services that assists the household in maintaining their housing.

PSH is a strategy that permanently houses individuals and families as quickly as possible. Each household has a lease in their name and is connected to mainstream services in the community. Supportive services are expected to remain engaged with the households for the entire time the household is enrolled in the program.

Arlington County has implemented the following Best-Practice PSH Strategies:

- Housing Location Services for persons with high barriers to securing housing
- Moderate to long-term Rental assistance
- Flexible funding for security, utility deposits
- Supportive services in the home that can help with but not limited to:
    - Landlord/Tenancy resolution
    - Budgeting
    - Medication management
    - Connection to public benefits such as child care, SNAP, tax credits, Medicaid TANF, etc.

Typically, households have demonstrated a clear need for supportive services and without these supportive services, they will be unable to maintain their housing once placed. In some circumstances, households may be required to enlist the services of a representative payee that will be responsible for ensuring that monthly rent and other expenditures are paid.

The program agreement does not mandate participation in any services. The program does not require households to be employed; however, they are encouraged to work toward increasing their self-sufficiency to maintain their housing.

Rental assistance payments are not made to program participants, but only to third parties, such as landlords. In addition, an assisted property may not be owned by the grantee or the parent, subsidiary or affiliated organization of the grantee. No staff participating in these programs may benefit from them.

Clients to be served

HUD Notice CPD-14-012

Priorities for PSH

As adopted by the Executive Committee, all PSH beds shall use the order of priority established in HUD Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons, which defines which chronically homeless people get priority access to PSH beds.

Excerpts from HUD Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons (See full Notice at: HUD Notice CPD-14-012)

Order of Priority in CoC Program-funded PSH Beds Dedicated to Persons Experiencing Chronic Homelessness and PSH Beds Prioritized for Occupancy by Persons Experiencing Chronic Homelessness

(a) First Priority–*Chronically Homeless Individuals and Families with the Longest History of Homelessness and with the Most Severe Service Needs.*

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. has 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.

i. The CH 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. does not have severe service needs.

(c) Third Priority–Chronically Homeless Individuals and Families with the Most Severe Service Needs.
i. The CH 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. has severe service needs.

(d) Fourth Priority–All Other Chronically Homeless Individuals and Families.
i. The CH 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 the four occasions is **less than 12 months**; AND
ii. does not have severe service needs.

Severity of Service Needs
(a) For the purposes of this Notice, an individual who has the most severe service needs is one for whom **at least one of the following is true**:
i. History of high utilization of crisis services, including but not limited to, ER's, jails, & 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 the Service Prioritization Decision Assistance Tool (SPDAT). The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual.

The Strategy shall incorporate a lower barrier, Housing First model. This means households do not have participation requirements or pre-conditions to entry, such as sobriety or minimum income threshold, and prioritizes rapid placement and stabilization in permanent housing.

This includes the following households:

1. Individuals and families who lack a fixed, regular, and adequate nighttime residence including those residing in a shelter or a place not meant for human habitation and those exiting an institution where they resided temporarily;

Additionally the households MUST meet the following conditions:

2. Individuals and families who have been homeless for one continuous year; or
3. Individuals and families who have had four (4) episodes of homelessness in a three (3) year period;
4. Households MUST have a long-term disability (i.e. Serious Mental Illness)

Please reference the **Table 2 below**.

Table 2 – Categories that qualify a household for Permanent Supportive Housing (PSH)

Category 1	**Chronically Homeless**	A ‘‘homeless individual with a disability,’’ who: (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of literal homelessness.

Program participant eligibility must be based on the category and documentation of chronically homeless status as evidence from the initial intake through a centralized intake, and/or screening for street outreach and shelter workers. In either case, the program must have documentation of the household’s chronic homeless status (i.e. HMIS documentation) and the household’s disability (i.e. history of mental illness documented by hospital stays, official DSM diagnosis, etc).

Re-certifications:

There are no re-certification periods for households that participate in CoC PSH programs. While there are no re-certifications processes, programs should continuously evaluate all household’s need to determine if the household still needs permanent supportive housing. In many cases, households may need the program long-term and in other cases the households may stabilize and not require this level of program intervention after some time in the program.

Permanent Supportive Housing Admission Committee

TheCoC PSH Admission’s Committee (AC) has been established to review and make final admission decisions regarding households that have been referred to PSH. The AC has the following responsibilities:

- To establish the criteria upon which all chronically homeless persons will be evaluated, scored, and ranked. The ranking will determine which household should secure the next available unit.
- To review CoC PSH referrals to determine which households will be placed in PSH.
- To meet when there are program vacancies to determine how to prioritize the PSH pool to fill those vacancies.

The Admissions Committee shall be comprised of one (1) member from each the following organizations/programs from the Continuum of Care (CoC):

- Arlington Street People's Assistance Network (ASPAN)
- Department of Human Services/Clinical Coordination Program (CCP)
- Department of Human Services/Housing Assistance Bureau (HAB)
- New Hope Housing, Inc.

The AC uses the following criteria to remain impartial weighted measure to determine the next household that will receive the next opening slot for PSH programs within the CoC. The weighted measure will be based on the SPDAT score (above 37) and the following criteria in order of importance:

- History of service in Armed Services (Army, Navy, Marines, Air Force, Coast Guard)
- Length of chronic homelessness (Households that have been homeless the longest)
- Heavy user of system services (hospital, jail, mental health hospitalizations, etc.)
- Chronic Homelessness (based upon HUD's definition)
- Engagement (Level of program engagement with the household; can be documented through service transactions in ETO).

Providers

To provide PSH services there are three distinct providers that can provide households this program component. The providers are as follows:

- Arlington Street People's Assistance Network (In Roads, Home Bound, , Turning Keys (1), Turning Keys (2)
- Arlington County Government (Milestones, DHS-Permanent Supportive Housing Program)
- New Hope Housing (Just Home, Safe Haven)
- Volunteers of America – Chesapeake (Arlington County PSH)

Screening/Assessment

To be eligible for PSH programs a household must meet the HUD definition of chronically homeless described in Table 2. Households that have been screened and determined to eligible to receive PSH must follow these steps:

- Make a referral via the ETO/HMIS system. The referrals shall be routed to CoC PSH and must include the documented verification shown below.
- HAB will review the application for requirements and establish a time for the case to be presented.
- Upon conclusion of the presentation, the PSH Admission Committee will discuss and rank the household according to the CoC Priority Criteria.
- If accepted, the referral source will be informed via email of acceptance to the program.
- Case management services of the PSH will then work closely with Case management services of the emergency shelter and/or street outreach program to successfully transition the household into housing.
- If needed, the household can be referred to Housing Location Services via the ETO system.

Documentation

To be eligible for PSH, households/providers must provide the following documentation**:**

- Proof of Arlington residency
- Proof of Income (if applicable)
- Proof of Veteran Status (if applicable)
- Chronic Homeless Checklist and Homeless Chronology
- ETO/HMIS Program History
- SPDAT
- Proof of disabling condition

Vacancy Tracking

To the extent possible, the HAB will use HMIS to manage the vacancy tracking system in conjunction with the PSH providers.

Programs will be required to post vacancies in homeless designated beds in HMIS within eight (8) hours of unit/bed availability. If providers know of an impending vacancy, they will be required to post the anticipated availability date within two (2) business days of being made aware of such availability and updating HMIS with the actual availability date once the bed becomes vacant. Programs must update vacancy information in HMIS within eight (8) hours of a unit/bed being filled. Exceptions to HMIS requirements and related processes for referrals to and from other systems not using HMIS will be defined in the Policies and Procedures Manual.

Terms of Assistance

Households entering a PSH program have no term limit. However, all CoC PSH program have the following standards:

- Households should be identified as **chronically homeless** prior to entering the program.
- Additionally the household demonstrates a need for supportive services that can assist the household in maintaining their housing once placed.

- All households with income are responsible for paying 30% of their income towards the monthly rental costs.

- Rental assistance is tenant-based rental assistance that can be used to follow individuals and families as long as they are still identified as participants in the designated PSH program.

- Programs must provide the appropriate level of case management in order to assure housing stability.

- At no time are participants required to engage in specific services.

A hallmark of Permanent Supportive Housing (PSH) programs is **Income□based Subsidy.** Under an income□based model, a household pays a specific percentage of its income towards rent and utilities (e.g. 30 percent). When partnering agencies are utilizing the income-based subsidy, the household's rent should be calculated using HUD's **Rent Calculation Form** to determine the portion of the households rent to be paid.

Housing Location

When households are moved into a new unit. The rent must meet two standards:

- Rent Reasonableness – rent is equal to or less than other like units in the area.
- Fair Market Rent (FMR) – rent (including utilities) is at or below the HUD established FMR for the unit size in the area.

Housing Quality Standards

All units that a participant moves into must be deemed habitable and conform to the County code. A Habitability Standards form must be completed and included in program

participant records in all applicable cases. Housing that is occupied by families with children and that was constructed before 1978 - must also comply with Lead Based Paint inspection requirements, per the Lead Based Paint Poisoning Prevention Act. A Lead-Based Paint Visual Assessment form must be completed and included in program participant records in all applicable cases.

Landlord Marketing

Successful marketing efforts often utilize the following selling points to explain the "win-win" for landlords in partnering with social service programs:

- Households are provided individualized case management before and after the move, including tenant education, budgeting, household management, employment assistance, and crisis intervention.
- Services are often provided on-site through regular home visits (often as needed).
- Landlords have access to dedicated point persons responsive to their concerns and needs, and can expect prompt intervention with tenants when requested.
- Program participants and sometimes other tenants in the same buildings – have access to, or can be linked to, intervention programs to address issues or crises (e.g., rent-to-prevent eviction assistance).
- Double security deposits can be paid on behalf of tenants.

Termination

Any individuals participating in an Arlington County CoC PSH Program must receive written notification of the agency's grievance policy. Grievance policies must provide specific procedures to be followed for any disputed rapid re-housing program decision impacting the participant's financial assistance.

The agency may terminate assistance to a program participant who violates program requirements. However, barring any safety issues or concerns, the household should be discussed via case conference that includes members of the PSH Admissions Committee.

PSH Providers will (1) Provide written notice to the program participant containing a clear statement of the reasons for violation/termination; (2) Provide review of the decision, in which the program participant is given the opportunity to present written or oral objections before a person other than the person (or a subordinate of that person) who made or approved the termination decision, (3) Request and attend a DHS case conference if issues are not resolved; and (4) Provide prompt written notice of the final decision to the program participant. Aforementioned documentation must also be submitted to DHS HAB.

HMIS Reporting

PSH agencies are required to report program participant-level data, such as the number of persons served, demographic information and financial assistance provided in the Homeless Management Information System (HMIS) database.

Please note that domestic violence assistance providers may, in lieu of HMIS, use a comparable system. Such providers are responsible for meeting all HMIS data standards and reporting requirements regardless of the data collection system utilized.

Note: CCP/CAS now tracks DV households anonymously in HMIS.

Outcome Measures

Partnering agencies should meet the outcome measures established in the CoC Report Card as well as the outcomes measures established by the State.

Veterans

The Continuum of Care is committed to ending Veteran homelessness. If/when a veteran is identified at intake for Prevention, Diversion, Rapid Rehousing or Permanent Supportive Housing, the worker must update HMIS record. This provides the basis for a robust service response that includes:

- Coordination with VA for HUD-VASH and SSVF
- Prioritizing non-VA eligible Veterans for CoC assistance

Section VI Emergency Shelter

Overview and Purposes

The County views emergency shelter as intended to be an emergency resource of last resort, used only by people who are literally homeless and have no other option to resolve their homelessness. The CCP/CAS will approve only Arlington households that are currently literally homeless for emergency shelter placement and will not maintain households who are not literally homeless on a waiting list for shelter.

At intake, all efforts to divert the households to safe, alternative housing will be made. If the safe, alternative housing is not permanent, efforts will be made to sustain the alternative housing until permanent housing can be achieved.

Clients to be served

Emergency shelter will serve households (individuals and families) who meet the HUD definition of homelessness which is described in Table 4 below:

Table 4 – Definitions of Homelessness

Category 1	**Literally Homeless**	Includes households who lack a fix, regular, and adequate night time residence, meaning: • Have a primary residence that is a public or private place not meant for human habitation; • Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, and local government programs); or • Is exiting an institution where (s)he has resided for 90 days or less **and** who resided in an emergency shelter or place not mean for human habitation immediately before entering that institution.
Category 3	**Homeless under other Federal Statutes** (*and requesting shelter*)	• Homeless Under Other Statutes Unaccompanied youth under 25 years of age, or families with children and youth, who do not meet any of the other categories but are homeless under other federal statutes, have not had a lease and have moved 2 or more times in the past 60 days and are likely to remain unstable because of special needs or barriers.
Category 4	**Attempting to Flee External Harm to Self**	Any individual who: • Is fleeing or disengaging, or is attempting to flee or disengage, domestic violence, sex trafficking, sexual exploitation, gang participation, and/or organized crime; **and** • Has no other residence; **and** • Lacks the resources or support networks to obtain other permanent housing.

Prioritization for emergency shelter placement will be based on the CAS assessment which considers length of literal homelessness and the level of vulnerability.

Providers

In Arlington County, there are four (4) distinct emergency shelters:

- Two emergency shelters for single adults
    - Residential Program Center (RPC): 44 bed-shelter (for males and females)
    - Homeless Services Center (HSC): 50 bed-shelter; 5 medical respite beds; and space for 25 persons in cases of emergency weather situations
- Two emergency shelters for families with children and single females
    - Family Home: 21 bed-shelter (also serves single females)
    - Sullivan House: 50 bed-shelter (also serves single females)

Screening /Assessment

The Diversion Specialist will complete the **Diversion Assessment Tool**if a household cannot be diverted from homelessness and needs to access services in the homeless system. The Diversion Specialist will have access to the information on the **Triage Form** as well as shelter stay history from HMIS (if there is a shelter history).

Once a household enters a single or family shelter, the provider will continue to complete the Family SPDAT/Individual SPDAT when the household has spent no fewer than 7 consecutive days in the shelter system. These assessment tools will be used to determine the next step housing intervention necessary to resolve homelessness for any household that needs additional assistance beyond shelter.

Documentation

Since households have been assessed by the CCP/CAS, there is no specific supporting documentation that providers need to accept a household for emergency shelter. All providers should have access to the intake information completed via HMIS.

Vacancy Tracking

To the extent possible, the CCP/CAS will use HMIS to manage the vacancy tracking system. Programs will be required to post vacancies in homeless designated beds in HMIS within eight (8) hours of unit/bed availability. If providers know of an impending vacancy, they will be required to post the anticipated availability date within two (2) business days of being made aware of such availability and updating HMIS with the actual availability date once the bed becomes vacant. Programs must update vacancy information in HMIS within eight (8) hours of a unit/bed being filled. Exceptions to HMIS requirements and related processes for referrals to and from other systems not using HMIS will be defined in the Policies and Procedures Manual.

Prioritization of Referrals

Households will be prioritized for emergency shelter placement based on the length of literal homelessness and/or their Vulnerability. Those who have been homeless the longest and who are the most vulnerable will receive priority access.

Case Conferencing

Should issues arise that involve non-compliance or adherence to program guidelines, the shelter staff should work with the household to determine how to collectively address the issues. This plan should be in writing and specify S.M.A.R.T goals that are clearly explained to the household. This plan should be sent to the Routing and Referral Manager in CCP. If after a 30 day period the household has not made significant attempts to address adverse behaviors, the shelter worker should seek a case conference through DHS. The purpose of the face-to-face case conference will be to make household aware of their housing options and how DHS and non-profit partners can work with the household on be successful. Shelter staff will work with the household on the updated service plan objectives for the next 30 days. If after this 30-day period, the household is still not compliant, the household may be discharged.

Medical Respite Beds

The Medical Respite Program (MRP) in Arlington County provides 5 beds in the HSC center. The use of the beds is dedicated to homeless Arlington clients with an acute medical condition from which they are recuperating. The stay in the MRP is to last no longer than 30 days at which time the patient may be discharged to the general shelter population at the Homeless Services Center (HSC), Residential Program Center, or alternative housing.

To be eligible to enter the MRP, the client MUST:

Meet federal definition of homelessness

- Be an Arlington resident, 18 years of age or older
- Have an **acute** medical condition or injury requiring bed rest and short-term respite care
- Be able to perform ADL's without assistance and be independent in mobility (with or without devices such as wheelchair, crutches)
- Be psychiatrically stable
- Have the potential to recover and leave the Medical Respite Program within 30 days

Who is NOT eligible?

- People who are not Arlington residents, i.e. individuals from other counties or states

- People without an ACUTE medical condition and from which they can recover without this care, e.g. someone with chronic diabetes or an amputee of long standing
- Someone with a mental illness diagnosis ONLY

Program Specifics

The program operates as a triage facility. It does not provide clinic services. Up to 40 hours of nursing services is available. Specific staff assigned to the program are the Nurse Practitioner (NP) who provides care to clients in the MRP and to the general population of the shelter and the day program; the MRP Coordinator who serves as liaison with the NP and the Virginia Hospital Center (VHC); and a Shelter Case Manager who is assigned to clients in the MRP.

Referrals are submitted from the Virginia Hospital Center (VHC) and other Arlington agencies to the Nurse Practitioner and are reviewed from Monday through Friday during normal business hours. If necessary the Nurse Practitioner will contact CAS staff to verify Arlington Residency. Admissions are made on weekdays from 8 AM to 2 PM., Monday through Friday. Alternative arrangements must be approved by the Shelter Director or the Executive Director of the Contractor with immediate notification to designated County staff. The expected length of stay must be clearly defined when client enters MRP based on the findings of the NP.

MRP participants will have individual rooms that are separated from the general shelter and the day program populations. Each will each be assigned to a Shelter Case Manager who will triage weekly with NP on shared clients.

The VHC, the primary referral site to the program, maintains responsibility for several tasks needed to operate the MRP. The VHC will coordinate with Home Care agencies to provide charity skilled care at the HSC on a patient specific basis. It will provide the patient with an initial minimum (one week) supply of medications for relatively inexpensive medications, such as antibiotic, excluding any narcotics. VHC will coordinate with Home Infusion Company to provide infusion services on a patient need basis for those who have **no history** of poly-substance use and are able to self-administer the IV infusion.

Program data will be recorded in the Homeless Management Information System (HMIS). Vacancies will be reported immediately to the designated CAS staff.

Forms:

1. Program Grid (needs to include CJ and EFA)

2. Triage Form

3. SPDAT for Singles

4. F-SPDAT

5. Shelter Intake Form

6. Case Conference Request Form