

Attachment C

Scope of Work: Assessment, Navigation & Housing Stability Case Management

A. Assessment.

The Assessment is the process of gathering information about a person presenting to the homeless response system. Assessments are progressive, meaning information gathering occurs at various stages for different purposes, often by different staff. Assessments must avoid unnecessarily long and intrusive interviews or repeating the same process at every place assessed.

It may be appropriate to integrate stages of the assessment into a single participant interaction. The various stages of an Assessment include:

- Initial triage: Identifying the nature of the crisis and ensuring person's immediate safety
- Diversion: Can occur as part of initial triage or separately; focused on assisting the person to examine their resources and options other than entering homeless system.
- Intake: Occurs when person accepts crisis assistance, such entering a shelter or agreeing to work with outreach. Intakes should only collect the necessary data needed to enroll the person in a homeless assistance project. (Ex: CoC Entry).
- Eligibility Screening: Eligibility screening considers the potential participant's likelihood of being eligible for a program based on eligibility requirements of available programs such as RRH, SSVF, TH, PSH, or VASH.
- Vulnerability Assessment: This incorporates a prioritization component, level of risk and vulnerability, and identifying barriers. (Ex: VI-SPDAT, F VI-SPDAT, or TAY VI-SPDAT).
- Comprehensive Assessment: Refines, clarifies, and verifies the person's history, barriers, goals and preferences. Together staff and person develop a housing plan for exiting homelessness. For lower acuity persons or those not eligible for Supportive Housing, this includes connecting to community resources and any safe and appropriate housing options (room rentals, shared housing, reunification, etc.)

As an agency participating in our community's CES through Assessments, agency agrees to

1. Ensure all Assessors attend initial and annual Assessment trainings, including Diversion, Trauma Informed Care, Safety Planning for DV.
2. Utilize HMIS to determine what, if any, previous assessment stages participant has already engaged in, to avoid repeating steps unnecessarily.
3. Provide initial triage and Diversion conversation.
 - a. For homeless families requesting shelter who are unable to be diverted, complete Shelter Matching Tool in HMIS.
 4. For those unable to be diverted and who request continued crisis services, complete intake in HMIS (release of Information and CoC Entry). For ES or Outreach, allow for time to resolve homelessness prior to screening for Supportive Housing.
 5. For those unable to resolve homelessness, screen to determine if participant is a target population (Chronically Homeless, Youth, Family, Veteran) for Supportive Housing.

6. For Target Populations, complete Vulnerability Assessment (VI-SPDAT with Case notes) and enter in HMIS.
7. If not target population, help connect to other community resources or natural supports.
8. Document all work in HMIS (or comparable database for Victim Service Providers) to track and monitor information and outcomes.

B. Housing Navigation

Navigation refers to any activities related to helping persons experiencing homelessness locate and move into permanent housing, whether supportive housing or housing without a subsidy. However for the purpose of this scope of work, activities are focused on Navigation assigned in registry with the goal of navigating someone into supportive housing.

Once a person has had an assessment using a VISPDAT, the coordinated entry process moves on to determining their priority for Supportive Housing. In order to verify eligibility for Supportive Housing, participants are assigned a Housing Navigator in Registry Management meetings who follows up with participant to verify information provided during assessment. Navigation is assigned in registry and prioritized based on length of homelessness and vulnerability.

As an agency participating in our community's CES through Navigation, agency agrees to the following

1. Ensure all Navigators are trained in HMIS, CES Overview and Navigation, Diversion, Trauma Informed Care, Safety Planning, LGBTQ+ Inclusivity, Race Equity.
2. Have representation at registry meetings to be available to discuss persons ready to be matched to programs or to take new persons on for Navigation.
3. After assignment in Registry, Navigator makes contact with participant to verify information provided during assessment in order to ensure participant is still homeless, in need of services, and meets program criteria.
 - a. If deemed ineligible, connect to natural supports and/or general community resources.
 - b. If deemed eligible, proceed with following steps.
4. For Family RRH Navigators only: Document updates in Navigation tracking sub-assessment in HMIS and add case notes as needed.
5. For all other Navigators, enroll participant into your project in HMIS, if not already enrolled, and update all fields as needed.
6. Help participant obtain all documents needed for programs (ID, Birth Certificate, Social Security Card, proof of homelessness, etc.) and upload into HMIS. **For Veterans, documents are not needed at time of referral.*
7. Send referral in HMIS to appropriate program:
 - a. Rapid Rehousing for Families or Youth (811 RRH);
 - b. Permanent Supportive Housing for Chronically Homeless (812 PSH);
 - c. Housing and Services for Vets (986 CES Intake SSVF).
8. If and when a participant is assigned to a program, coordinate a Warm Hand-off with participant and new Housing Case Manager.

- a. For persons residing in shelters, the Warm Hand-Off should occur within 72 hours of the referral.
- b. For persons living outdoors, regular and ongoing efforts to locate participant will be made for up to 90 days. All attempts to locate must be documented in HMIS case notes.
- c. For referrals to Single Site programs, join participate for application appointment, which may include helping them obtain additional documents (ex: bank statements)needed to make application.

C. Housing Stability Case Management - Phase 1 of 2: Locating and Planning for Housing

All Supportive Housing Programs participating with CES should anticipate referrals for high acuity participants. HUD expects that participating programs keep barriers to entry low and have a person- centered approach to working with new participants.

1. Service Delivery Expectations

a. Trauma Informed Care

- i. Services are delivered with a trauma informed approach. Case Manager actively works to avoid re-traumatizing, utilizing assessment tools (SDPAT, other evidenced-based tools) to better understand participant’s experience of trauma.

b. Harm Reduction

- i. Case Manager works with tenant on how to reduce harm associated with risky behaviors related to substance use, not engaging with mental health providers, intimate partner violence, guests policies once housed, etc.

c. Recovery Oriented Care

- i. Case Manager works with tenant on self-directed recovery plans related to substance use disorders and mental health.

2. Participate in Registry Management meetings to link eligible persons to supportive housing.

a. Participate in registry meetings to provide updates on program vacancies

b. Fill Housing Case Manager Caseload with referrals identified in CES registry meetings.

c. Conduct first face-to-face meeting with participant and Navigator:

- i. Within 72 hours - for persons residing in shelter at the time of referral.
- ii. As soon as participant is located - for unsheltered persons. Navigator will continue to search for up to 90 days for unsheltered persons.

d. In the rare event a person is rejected by a program, update the referral status to declined, indicate in case notes the reason for decline, and inform CES via email.

- e. Complete Program Intake and begin process of obtaining safe and stable housing.
 - i. When needed, contact CES for emergency shelter referrals for unsheltered participants.
 - ii. When appropriate and as funding allows, link participant to bridge housing until permanent housing is available
 - f. Begin Housing Stability Plan via Case Plan notes or other Housing Stability tool.
 - i. Ensure Housing Stability Plan incorporates barriers to housing, participant strengths and goals to obtaining and maintaining housing and plan to meet goals.
3. Help participant address issues that may impede access to housing (such as credit history, arrears, and legal issues).
- a. Conduct local background check using publicly available online data sources (florida.arrests.org)
 - b. Help obtain credit report on individual/household.
 - c. Review credit reports with individual/household to identify potential barriers with landlords.
 - d. Work with individual/household to create financial stability plan that includes debt reduction and addresses outstanding debt (including judgments).
 - e. Assist with linkage to legal services and credit repair agencies when appropriate.
 - f. Assist with writing Requests for Reasonable Accommodations (RRAs) when appropriate. RRAs may be submitted with the application for housing or after a denial from the landlord/property manager. (Submit copies of first 3 RRAs to HSN for review prior to submitting to landlord.)
 - g. Track use of and outcome of RRAs in HMIS via case plan case notes.
4. Assist participant with identifying and selecting safe and affordable housing based on their unique needs, preferences and financial resources.
- a. Discuss housing preferences with each assigned participant including:
 - i. Long-term affordability in relation to current or anticipated income
 - ii. Safety
 - iii. Location preferences in relation to other life goals
 - iv. Potential landlord barriers
 - v. Accessibility needs
 - b. Complete Housing Needs Form on all assigned head of household, if working with HLT.
 - c. Enter Housing Needs Form data onto hlthousingneeds.com once completed.
 - d. Review potential housing units with participant.
 - i. Ensure transportation to potential units for evaluation by participant.

- ii. Review each unit's location, size and design with participant in the context of overall household goals for housing stability.
 - iii. Assist participant with completing applications, paying special attention to barriers related to limited English proficiency, functional illiteracy, cognitive challenges, etc.
 - 1. Accompany participant to see all potential units (with tenant's consent).
 - 2. Be present at the signing of the lease, with tenant's consent.
 - e. Pay application fees, if appropriate and in accordance with the policies of the housing program.
 - f. Update ongoing work via Case Plans in HMIS on progress of housing selection, noting reasons for units declined, applications submitted, supports provided, status of applications submitted, and reasons for denials if any.
5. Help participant negotiate manageable and appropriate lease agreements with landlords
- a. Review template lease of units in which the participant has interest.
 - b. Once an application is made on a unit, email HLT to update.
 - c. *If HSN is subsidizing rent:* Once HLT has inspected the unit and confirms a lease can be signed, Case Manager submits tenant's first month rent calculation to HSN with information and documents needed to establish rental assistance contract with the landlord/property manager:
 - i. Amount of deposit
 - ii. Date lease will be active
 - iii. Amount of pro-rated first month's rent to be paid by household, if applicable
 - iv. Amount of rent to be paid by household during first month(s) of financial assistance
 - v. Any changes in amount of rent paid by the household submitted to HSN by the 15th of the month, to be reflected in payment made to landlord/property manager on the 1st of the following month.
 - d. Case Manager coordinates with participant a lease signing
 - e. Once a lease is signed, furnish copy of lease to HLTFinance@hsncfl.org within 3 business days of signing, if HSN is subsidizing rent.
 - f. Review all lease components with tenant, focusing on tenant rights and responsibilities, including but not limited to:
 - i. Rent payments and fees found in the lease, with emphasis on fees not in the lease that cannot be charged to the tenant
 - ii. What it means to be a good tenant and good neighbor to avoid landlord notices
 - iii. Limits on overnight guests

iv. Maintenance protocols

- v. Landlord and maintenance accessing the unit for repairs
- g. Complete interim update in HMIS to update move-in date and new permanent housing address.

D. Housing Stability Case Management - Phase 2 of 2: Supporting Housing Stability –

1. Create Individualized Housing Stability Plan with tenant, that may include but not limited to
 - a. Housing Stability Goals (use SSOM or SPDAT tools to help gauge service needs)
 - i. Moving into new unit
 1. Utilities
 2. Furniture
 3. Household goods
 4. Transportation of items to new unit
 5. Household setup
 - ii. Unit orientation, as appropriate
 1. Emergency exits
 2. Maintenance activities to be done by tenant
 3. How and when to submit a maintenance request to landlord
 4. On/Off for all utilities (water valve, circuit breaker, etc.)
 5. Use of appliances
 6. Cleaning techniques for the surfaces in the unit (carpet vs. tile; wood vs paint)
 7. Social and Community Connections
 - iii. Community and Social Integration - Offer supports to connect to faith groups, peer support groups, volunteering, voting, community gardens, events, community activities, etc.)
 - iv. Increasing income – Case notes must include concrete steps for increasing income through applying for benefits or suitable employment
 - v. Transportation to:
 1. Medical or Behavioral Health appointments
 2. Employment
 3. Child-care/schools
 4. Groceries
 5. Support group meetings
 6. Social networks, including faith-based affiliations
 - vi. Work with tenant to develop disaster weather plans, if appropriate
 - vii. Work with tenant to develop crisis plans, as needed
 1. Crisis plans may include what to do when housing is at risk, intimate

partner violence, relapse, planning for trauma triggers, etc.

- viii. Develop plan for frequency of caseworker visits and phone contact based on needs of household, and adjust as needed
 1. How many visits/calls the first week of tenancy?
 2. How many visits/calls the first month of tenancy?
 3. Schedule for how visits/calls will be tapered (for RRH programs)
 4. Criteria and process for increase of more intensive schedule of visits/calls if needed
- ix. Any payments to be made on behalf of the household
 1. Rental assistance to be paid by HSN
 2. Utility assistance to be paid by agency and reimbursed by HSN
 3. Case manager and supervisor to agree on strategic use of available funds
2. Provide flexible services and supports for participants to encourage successful housing stability.
 - a. Update Housing Stability Plan (every 3-6 months depending on program), with emphasis on how tenant is achieving housing stability. Include detailed actions to be taken by household and by agency to achieve housing stability.
 - b. Submit required documentation to HSN by 5th of each month to ensure rental assistance paid to landlord by 1st of the following month, if HSN is subsidizing rent.
 - c. Submit revised rent calculation or other required documentation needed to make a determination regarding whether to alter or discontinue financial assistance as changes in circumstances dictate or when ongoing housing stability is obtained. (Any such documentation must be submitted to HSN by the 15th of the month to ensure that payments to landlords are appropriately adjusted or discontinued for the following month.)
3. Monitor participant's housing stability and be available to adjust supports as tenant needs require.
 - a. Services must be provided during any month that the participant receives rental assistance.
 - b. For RRH: Case Management services should be provided as needed to promote housing stability and retention during months that rental assistance is not provided. (Services need not be provided in consecutive months.)
 - c. For PSH:
 - i. In Scattered site programs, Case Management services continue even in the event of eviction and/or during multiple housing placements.
 - ii. In Single-Site PSH programs, the Case Manager/Program Manager should request a PSH Staffing for any tenants at risk of losing their unit. Staffing

Committee can make recommendations for preventing an eviction, as well as if tenant is eligible for a project transfer if evicted. If tenancy remains at risk, CES is notified in advance to begin planning for a potential transfer to another PSH program. Transfers are pending additional PSH program capacity. CES coordinates with Outreach and single site Case Manager if tenant is evicted prior to a transfer.

Outreach will remain engaged with participant until transfer is available.

- d. Develop plan for follow-up with and assistance to individuals/households who had previously stabilized but need additional assistance due to onset of a new crisis, if services had previously been reduced or stopped.
4. Provide or assist individual/household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. When necessary, provide or ensure individual/household has access to resources pertaining to:
 - a. Employment
 - b. Benefits
 - c. Community-based services or activities
 5. Develop and implement a plan for progressive engagement of participants who receive housing subsidies but refuse ongoing Case Management services and supports.
 6. When appropriate, develop and implement a discharge or “step down” plan for individual/household once stabilized and not currently at serious risk for returning to homelessness.
 - a. Peer supports
 - b. Connection to family or other natural supports
 - c. Independent Living Skills
 - d. Wellness or Illness Self-Management
 - e. Connection to Community-Based supports and services
 - f. Financial Capacity