

LA-503 New Orleans-Jefferson Parish-Kenner
Continuum of Care (CoC) Written Standards

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Adopted by the CoC Governing Council on
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Standards of Care, Section 1: Street Outreach (SO)

Street Outreach (SO) identifies people living in places not intended for human habitation, builds a relationship with them based on trust and empowerment, and helps them navigate into housing that is safe and permanent. Street Outreach is an important entry point into the CoC's Coordinated Entry System through their work to engage non-service seekers to quickly navigate them into housing. Outreach teams will continue to follow participants after they are placed in emergency shelters as needed, or if the sustained client participant-worker relationship is needed to assist the client to obtain and/or maintain permanent housing.

Staff Qualifications:

Staff should be knowledgeable about and demonstrate basic competence in the following areas: harm reduction, motivational interviewing, strengths-based care, participant centered care, and trauma-informed care.

Staff must be able to work in environments where participants are living: outdoor locations including those that are hidden, near bridges, near levees, or in wooded areas.

Outreach teams should have at least one staff member trained through SSI/SSDI Outreach, Access, and Recovery (SOAR) or must refer to someone who is trained in SOAR, to assist clients to obtain SSI/SSDI income.

Street outreach engages in the following activities:

- Conduct outreach in teams of no less than 2 people
- Conduct outreach 8 p.m. – midnight
- Conduct night outreach at least 2 nights each week per FTE between the hours of 8 p.m. and 2 a.m. for at least 8-10 hours of night outreach weekly
- Serve as an entry point into the CoC's coordinated entry system
- Focus on the chronically homeless and other vulnerable populations (veterans, families with children, women) as prioritized by the CoC

Each FTE outreach worker should maintain an active caseload of at least 30 clients engaged at any moment in time. Of the client case load, 10-20 clients will be in the process of being navigated into housing at any moment. Outreach shall have a goal to refer clients to permanent housing within 30 days after enrollment.

Client Enrollment:

Clients who are not literally homeless shall be referred to the Information & Referral office or referred to non-homeless service providers based upon their needs.

Organizations with outreach teams shall have written policies regarding commitment to fair housing, access for persons with disabilities, and language accessibility.

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Attempt – when an outreach worker visits a location seeking to find a specific participant. Three failed efforts to document a person’s homelessness will be the maximum number of attempts for someone who has not been contacted or enrolled.

Engagement – when an outreach worker adds a participant to their caseload after homelessness is documented. The participant does not need to sign the HMIS consent.

Contact – any time an outreach worker makes contact with a participant designed to engage the participant. HUD expects outreach workers to record every contact made with each participant in HMIS. Contacts include conversations between the outreach worker and participant regarding the participant’ well-being or needs, office visit to discuss their housing plan, or a referral to another community service or telephone contact.

Enrollment- a contact in which a participant consents to complete the intake process with the outreach program. The client is assessed and an initial case plan is developed. The engagement date is also a contact in terms of HMIS reporting. (If no packet is completed, the encounter is only a contact.) HMIS Data Quality Monitoring begins at Engagement.

Inactive – An outreach participant may be made inactive, and exited from HMIS, in the following circumstances:

- The client has not been seen in at least 90 days despite attempts occurring at least bi-weekly.
- The client exits street homelessness for a time expected to be at least 90 days.
- The client has been institutionalized and is expected to remain in the institution for at least 90 days.
- The client persistently refuses services at least bi-weekly for 90 days and the outreach team has observed no vulnerability or health issues of the client.
- The client has obtained housing.

Coordination:

Each outreach person attend weekly outreach meeting conducted by UNITY Welcome Home Friday at 9 a.m. at 2408 Baronne Street, except for the SPPA meetings which are held on the third week of every month. Outreach meetings coordinate street outreach to ensure all areas of the Continuum of Care in Orleans and Jefferson Parish are covered.

Each outreach person will attend weekly navigator meetings to prioritize clients for navigation into housing. Veteran navigation is held Mondays at 1 p.m. Chronic navigation is held Mondays at 2 p.m. Family navigation is held bi-weekly at 10:30 a.m. All navigation meetings are held at 2407 Canal Street in UNITY’s third floor conference room.

Homeless Documentation

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Homelessness shall be verified by street outreach only at night and only through verification of two outreach workers with a location and date.

Outreach will respond to citizen reports to verify homelessness within 24 hours for families with children or in the event that a vulnerable person is in danger. Outreach will respond within 7 days to reports of someone living in an abandoned building. Such outreach will be conducted during the day with the outreach workers leaving a card if unable to contact the client at that visit.

Data

HMIS data shall be input within 7 days of the outreach contact. HMIS shall be used as a record to document homelessness.

VI-SPDAT assessments will be conducted as soon as possible with outreach clients, ideally at first contact. Re-assessments can be conducted as new information is obtained or as circumstances change for a client.

Timeliness:

CoC standards for housing clients quickly means outreach must maintain the following timeliness standards:

- HMIS data entry
- VI-SPDAT
- Determination of chronic status (episodes and disabling condition – self reported)
- Documentation of chronic status and disabling condition
- Completed PSH application information (including whatever vital records are necessary for the application)
- Warm hand-off to housing agency
- Assistance in locating client as needed/assist housing client as needed

Role in PIT

All outreach teams in the CoC are required to attend planning meetings for the annual Point In Time Count. Outreach teams serve as team leads for the two nights of street count during PIT. All PIT survey forms must be returned to UNITY within 24 hours.

PIT survey data will be used for the master list that is used for the navigation of homeless into housing.

Navigation

Outreach shall follow the principles of Housing First to navigate clients as quickly as possible from the street to permanent housing with a goal to refer clients to permanent housing within 30 days once consent for housing is given by the client.

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Navigation is conducted for clients who are currently (and verifiable) literally homeless on the street, in a shelter, or living in an abandoned building.

Navigation begins when a client is engaged and then enrolled in services. Engagement shall include HMIS entry data, HMIS consent, assessment of client using the VI-SPDAT.

Navigation includes assisting the client to obtain all documentation needed for the housing intervention appropriate for their level of need which includes, but is not exclusive of the following activities:

- Transport client to obtain income or identification documentation
- Complete PSH applications
- Conduct a warm hand-off as the client is referred and approved for housing programs

Outcome Measures:

- Each outreach worker is expected to navigate and assist client obtain all documentation needed for a housing referral, a minimum of 5 clients each month into housing.
- 25% of clients (leavers and stayers) exit to permanent housing during a program year.
- 50% of leavers exit to permanent housing
- 50% of clients who have an unmet service need related to housing, mental health or chronic health, will be connected with appropriate services during the program year.
- 50% of clients will have mainstream benefits at exit

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Standards of Care, Section 2: Rapid Re-Housing (RRH)

In accordance with HUD regulations 24 CFR Part 578 governing rapid re-housing under the Continuum of Care Program, the following written standards have been developed for the provision of rapid re-housing (RRH) assistance. These standards will apply to all projects that receive CoC funding for the provision of rapid re-housing.

The goal of these standards is to synthesize the key elements of the HUD regulations governing rapid re-housing with the processes and priorities of the local Continuum of Care. RRH programs receiving funding through a competitive process may also be subject to additional criteria as set forth by that process, the statement of work in their recipient or subrecipient agreement, and the project description.

Rapid re-housing is designed to provide the services necessary to help homeless persons quickly regain stability in permanent housing after experiencing homelessness.

I. Eligible Program Participants

All clients to RRH programs will be referred from the Coordinated Entry System. RRH programs shall not maintain a waiting list. RRH programs shall not enroll any participants who were not referred from the Coordinated Entry System.

Eligibility is based on three criteria:

- A. Documented literally homeless (HUD Category 1)**
- B. Income**
- C. Assessment of Needs**

Clients must also meet eligibility for any program with a specific subpopulation focus (veteran, family with children, youth)

A. Homeless Eligibility

Rapid re-housing program participants must meet the standard of HUD's Category 1 definition of homelessness for individuals and families who lack a fixed, regular, and adequate nighttime residence:

- An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, etc.
- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals); or

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- An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

B. Income

No income is required to be eligible for the program. There is a maximum amount of income which can be no more than 50% of the Area Median Income(AMI). An exception can be made for clients with income above 50% AMI but below 80% AMI if approved by the Coordinated Entry System Coordinator based on an assessment of client needs and/or based on an accommodation for disabling conditions.

C. Assessment of Needs

The VI-SPDAT is the common assessment tool used by the CoC to determine appropriate referral to housing programs based on client needs. Clients with a score of 4-8 shall be referred to RRH programs as the intervention to end their homelessness. Clients with higher acuity may also be referred to RRH which may be used as a bridge to PSH. A Housing Barriers Survey may also be used to determine client needs.

D. Subpopulation

Referrals must meet all participant eligibility criteria as defined in the project description with HUD and the statement of work in any CoC agreement regarding subpopulation eligibility (veterans, families, youth). The CoC has the discretion to specify prioritization or add eligibility criteria if approved by the CoC Governing Council to meet needs of the CoC.

No other requirements shall be made for clients to enter RRH programs. Programs shall NOT have eligibility requirements regarding:

- Sobriety
- History of domestic violence
- Mental health
- Income or ability to obtain employment income

Fair Housing Protections

Rapid Rehousing programs shall follow HUD guidelines regarding the definition of family which does not require legal proof of familial relationships. Programs shall prevent family separation and prevent discrimination based on all protected classes in the federal fair housing act as well as state and local protections. HUD regulations also require programs to prevent discrimination based on sexual orientation and gender expression. Accommodations shall also be made for clients with disabling conditions.

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II. Standards for Amount of Rental Assistance

Providers shall determine the type, maximum amount and duration of housing stabilization and/or relocation services for individuals and families who are in need of rapid re-housing assistance through the initial evaluation, re-evaluation and ongoing case management processes.

Standards for determining the share of rent and utilities costs that each program participant must pay, if any, will be based on the following guidelines:

Participant Contribution:

All households will pay a percentage of their household income towards rent (and utility) expenses. Participants with no income at the time of their assessment will be assisted at the full value of rent expenses until income is attained, not to exceed three months. The amount the participant pays may increase over time and should be calculated according to the rent of the unit, utility costs, household income, and projected expenses.

1. The maximum amount of rent that a participant will pay is 100% of the rental and utility amount.
2. Households with income shall be expected to pay no less than monthly adjusted income towards rent and utility costs.
3. Providers may provide up to 100% of the cost of rent in rental assistance to participants. However to maximize the number of households that can be served with rapid re-housing resources, it is expected that providers will provide the level of need based on the goal of providing only what is necessary for each household to be stably housed for the long term.
4. Rental assistance cannot be provided for a unit unless the rent for that unit is at or below the Fair Market Rent limit, established by HUD. A complete listing of Fair Market Rents can be found at: <http://www.huduser.org/portal/datasets/fmr.html>
5. The rent charged for a unit must be reasonable in relation to rents currently being charged for comparable units in the private unassisted market and must not be in excess of rents currently being charged by the owner for comparable unassisted units.
6. Utility costs should be calculated according to the utility allowance worksheet, included in the determination of fair market rent and rent reasonableness.

For more details see sections 578.37 and 578.51 of the HUD CoC rapid re-housing and rental assistance guidelines.

III. Standards for Duration of Assistance

Prior to providing any rental assistance, the provider shall verify with ViaLink that the household is not receiving rental assistance from any other CoC, ESG or HOPWA program.

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All clients shall receive 100% deposit assistance.

In order to maximize the number of households the program is able to serve, financial assistance shall be provided in the most progressive manner, providing only the assistance necessary to stabilize the household in permanent housing.

Clients shall be notified at program entry that participation in services is voluntary but participation is reassessment is necessary to continue to receive rental assistance.

Participants should be assessed for needs on a monthly basis EXCEPT for clients with high acuity (9 or above on the VI-SPAT) shall be assessed every 3-6 months.

To continue to receive CoC-RRH assistance, a program participant's re-evaluation must demonstrate eligibility based on:

- Lack of resources and support networks. The program participant's household must continue to lack sufficient resources and support networks to retain housing without ESG or CoC program assistance.
- Need. The recipient or sub-recipient must determine the amount and type of assistance that the individual or family will need to (re)gain stability in permanent housing.

It is anticipated that clients below 50% AMI income will receive 1-3 months of rental assistance based on the monthly reassessment of needs. Exceptions to this can be requested from the Coordinated Entry Manager.

Participants may be eligible for rapid re-housing assistance for multiple instances based on their need. However, if a participant needs assistance more than once, the participant will be subject to a re-assessment process for a different level of service intervention. However, no more than 24 months of assistance can be provided during any 3 year period.

There must be a lease between the landlord and the tenant and the lease must be for at least one-year, renewable for at least one year and terminable only for cause.

IV. Standards for Type of Assistance

Providers may use funds for rental assistance costs and eligible services (according to their approved budget), including the following: security deposits, first month's rent and/or last month's rent, eligible supportive services, repairs for property damage, one-time moving costs and one-time utility deposits.

V. Participant Enrollment

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Based upon the VI-SPDAT assessment, length of time homeless, and any other factors established by the CoC, homeless families and individuals will be referred to housing and services most appropriate to their situations and needs. All referrals to Rapid Rehousing programs shall be made through the Coordinated Entry System. Providers shall NOT create their own waiting list.

- All openings must be reported to the CoC Coordinated Entry System within one business day.
- The CoC Coordinated Entry System will ordinarily make a referrals within 5 business days of the date the opening was reported.
- The RRH program is expected to house the client within 14 days.

The RRH agency shall go to the client's current location to conduct intake interview and begin the housing search process with the client.

VI. Supportive Services

A. Housing Identification

- Assist the client to find units, call landlords, transport client to view units and visit landlords, conduct HQS inspection.
- Staff are trained on housing identification, landlord tenant rights and responsibilities, and other core competencies. The program shall have written policies and procedures for landlord recruitment activities, including screening out potential landlord partners who have a history of poor compliance with their legal responsibilities and fair housing practices.
- The program shall offer a basic level of support to all landlords who lease to program participants. This policy should include (at a minimum): Program staff will respond quickly (within one business day) to landlord calls about serious tenancy problems; seek to resolve conflicts around lease requirements, complaints by other tenant, and timely rent payments, and whenever possible, negotiate move-out terms and assist the person/household to quickly locate and move into another unit without an eviction
- Program requires staff to explain to participants about basic landlord-tenant rights and responsibilities and the requirements of their specific lease.
- Program provides participants with multiple housing choices within practical constraints. The program has a responsibility to conduct housing search with the client without precluding clients from conducting their own independent search.
- Program will assist participants to make an informed housing choice with a goal that the participant will be able to maintain after program exit, even when the household will experience a high housing cost burden.
- When closing a case, the program will provide information to landlord about how they can contact the program again if needed and what kind of follow-up assistance may be available.

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B. Case Management Services

RRH program participants are required by HUD regulations to meet with a case manager not less than once per month. Providers may also provide case management services for up to six months after rental assistance stops. Case management services should be provided in the client's home with follow-up conducted over the phone, in the office, or other locations. Providers must make all reasonable attempts to meet with their clients in person and as appropriate. If unable to meet in person, the program must document in writing why they were unable to do so and what attempts were made to meet with the client.

Due to the short-term nature of the program, the focus of case management is to link the client to community resources, increase client income, and reduce barriers to housing.

Case management plan for each client will be determined based on the assessment of service needs. The goal of case management is to assist the client to quickly obtain permanent housing and maintain permanent housing.

Case plan will include:

- Increase income
- Review of lease
- Landlord relations
- Utilities
- Connection to community resources including child care, employment, mental health, health, and mainstream benefits

Providers must assist each program participant, as needed, to obtain appropriate supportive services, including assistance in obtaining permanent housing, medical treatment, mental health treatment, counseling, supervision, and other services essential for achieving independent living; housing stability case management; and other Federal, State, local, or private assistance available to assist the program participant in obtaining housing stability including but not limited to: Supplemental Nutrition Assistance Program, Social Security Disability Insurance (SSDI) , Medicaid, Women, Infants and Children (WIC) , Supplemental Security Income (SSI) , Child and Adult Care Food Program, and other mainstream resources such as housing, health, social services, employment, education services and youth programs that an individual or family may be eligible to receive.

Any family with school aged children (including pre-K) shall be referred to the Orleans or Jefferson Parish McKinney-Vento school liaison. Children enrolled in charter schools shall be referred to the liaison for that particular school or can be referred to the Orleans or Jefferson Parish liaison for assistance.

Inspections

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Rental assistance can only be made to units that meet the HUD Housing Quality (HQS) Standards prior to the assistance being made. Reinspections must be made no less than yearly, upon request by the client, or if the case manager believes the unit no longer passes inspection. Providers may utilize their own staff to perform HQS inspections. HQS inspectors are required to attend a yearly training.

Data Collection & Evaluation

All providers receiving rapid re-housing assistance must work with the CoC to track key data elements for analyzing the success of the program including the use of HMIS data. Each provider must report to the Coordinated Entry System the date a referral is approved, the date the client is housed, the length of time of rental assistance provided, the length of time case management is provided, discharge status.

Security & Confidentiality Policies

The address or location of any housing or rental units funded under rapid re-housing of any program participant, including youth, individuals living with HIV/AIDS, victims of domestic violence, dating violence, sexual assault, and stalking; and individuals and families who have the highest barriers to housing will not be made public.

Discharge

If the reassessment determines no further need for assistance (rental and/or supportive services), the client will be notified at least 14-30 days prior to discharge.

Terminations, Complaints, Appeals & Grievance Procedures

All providers with rapid re-housing programs shall be required to have a termination and grievance policy.

Policies must allow an applicant to formally dispute an agency decision on *eligibility to receive assistance*. The policy must include the method that an applicant would be made aware of the provider's grievance procedure and the formal process for review and resolution of the grievance.

If a program participant violates program requirements, the provider may terminate the assistance in accordance with a formal process established by the provider. All providers must have policies that allow a program participant to formally dispute a provider decision to *terminate assistance*. The policy must include the method that a written notice would be provided containing clear statement of reason(s) for termination; a review of the decision in which the program participants is given the opportunity to present information before someone

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other than the person who made the termination decision; and a prompt written notice of the final decision to the program participant.

VII. Performance Measurements:

Process Measures:

- # families placed into permanent housing
- Average length of time from entry into shelter to placement into permanent housing (in days) each month
- Total landlord partners
- For families exiting the program, average amount of financial assistance for each family placed into permanent housing
- For families exiting the program, the average length of time financial assistance was provided for each family
- For families exiting the program, the average length of time in the program for which services were provided

Outcome Measurements:

- 95% families exit to permanent housing
- Less than 10% families that do not return to homelessness within 24 months after discharge
- 25% families exit with increased income
- 80% families exit with mainstream benefits

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Standards of Care, Section 3: Transitional Housing

Referrals to Transitional Housing (TH) programs will be made for clients only after they have been offered a permanent housing program. Clients who have been approved for RRH or PSH may be temporarily housed in a TH program (for up to 45 days) while they are in the process of obtaining the permanent housing.

Specific Subpopulations

I. Families

Referrals to Family RRH programs will be made only from the Master By-Name List of families who are literally homeless. Referrals will prioritize those with the highest needs and longest length of time homeless. Chronically homeless families will be referred directly to a PSH program if an opening is available. Because all CoC funded PSH is prioritized for the chronically homeless, non-chronic families in need of PSH will be referred to a long-term RRH program as a bridge until a PSH spot becomes available. Such families will remain on the Master By-Name List until the PSH referral is completed.

II. Youth

Families with a head of household age 24 or younger will be placed on the Family Master By-Name List for navigation. Young families will be referred to a youth specific program if suitable openings are available. If no openings are available in a youth specific program, the young family will be referred to any other program for which they are eligible.

Unaccompanied youth will be prioritized for youth specific rapid rehousing programs based on acuity and length of time homeless. Priority will be made to house unsheltered youth and those who may be subject to victimization.

III. Domestic Violence

When households come into contact with the Coordinated Entry System through an entry point or coordinated entry staff, an initial assessment will be conducted to determine if the household is fleeing domestic violence or attempting to flee domestic violence, dating violence, sexual assault, or stalking. A population appropriate triage tool will be used to identify the needs of the client.

People who are homeless because they self-report that they are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking will first be referred to victim-specific programs which will best fit their needs and is based upon client choice. Such

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referrals will be based on acuity and total length of time homeless, as well as an assessment of the client's current safety and risk of danger via a lethality assessment by a victim service or CES provider.

Coordinated entry and access point staff will safely refer the household to identified victim service providers, preferably with a warm hand-off including a phone call, transportation, or other transition to the victim service provider. Staff will ensure they have client consent to initiate any such warm hand-off or referral. Per the CoC Program Interim Rule at section 578.103(b), records containing personally identifiable information (PII) are to be kept secure and confidential and the address of any family violence project not be made public. If no victim specific programs are immediately available, families will be referred to CoC or ESG-funded programs as appropriate to end their homelessness and address their unique safety needs.

If the household does not wish to seek victim-specific services, they will have full access to the Coordinated Entry System and housing resources for which they are eligible. Safety planning and protections must be extended to victims of domestic violence who are staying at non-victim service provider projects. Such protocols include strict confidentiality of victim client records, information, and location. The non-victim service provider will also engage in safety planning and review with the household for the duration of program stay.

No CES entry point may deny access to programs or services on the basis that a participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking. All CES entry points must participate in safety planning training conducted by the CoC no less than yearly. Such training will be mandatory for CoC providers participating in the Coordinated Entry System. Each entry point must also ensure that victims have safe and confidential access to the CES process and immediate access to emergency victim services such as the domestic violence hotline and emergency shelter.

Consent for Data Entry

HUD ESG and CoC subrecipients who are victim service providers are prohibited from entering personally identifying information in HMIS. Additionally, all households, whether being served by a victim service provider or not, have the right to refuse to have their personally identifying information entered into HMIS and shared among providers within the CoC and are still able to receive services if eligible.

HUD Final Rule on the Violence Against Women Act (VAWA)

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Pursuant to the HUD Final Rule implementing the Violence Against Women Act (VAWA), the CoC has in place an Emergency Transfer Plan in the event that an internal or external emergency transfer may be necessary for those households that believe there is a threat of imminent harm from further violence if the tenant remains within their current dwelling unit. Please see forms attached in Appendix H or on the UNITY website at:

<http://unitygno.org/providers/violence-against-women-act-vawa-emergency-transfer-forms/>.

A tenant receiving rental assistance through, or residing in a unit subsidized under, a covered housing program who is a victim of domestic violence, dating violence, sexual assault, or stalking qualifies for an emergency transfer if:

- The tenant expressly requests the transfer; and
- The tenant reasonably believes there is a threat of imminent harm from further violence if the tenant remains within the same dwelling unit that the tenant is currently occupying; or
- In the case of a tenant who is a victim of sexual assault, either the tenant reasonably believes there is a threat of imminent harm from further violence if the tenant remains within the same dwelling unit that the tenant is currently occupying, or the sexual assault occurred on the premises during the 90-calendar-day period preceding the date of the request for transfer.

Households eligible for an emergency transfer shall be prioritized for internal and external transfers outside the general order of priority cited for the CES as noted above and in Appendix A of the CoC's [Coordinated Entry Handbook](#). Due to the unique safety needs involved, eligible households shall be prioritized above all other categories of transfer, as well as initial placements from the Coordinated Entry System.

CoC Program Interim Rule Section 578.51(c) establishes that a consumer may move to a different Continuum of Care geographic area to protect their health and safety and retain their CoC-funded rental assistance if they reasonably believe they are imminently threatened by harm from further domestic violence, dating violence, sexual assault, or stalking.

Documentation of reasonable belief of further domestic violence, dating violence, sexual assault, or stalking includes written observation by the housing or service provider; a letter or other written documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider, or other professional from whom the victim has requested assistance; a current restraining order, recent court order, or other court records; or law enforcement reports or records. The housing or service provider may also consider other documentation such as emails, voicemails, text messages, social media posts, and other communication, including certification from the victim, utilizing optional HUD

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Form 5382. Please see forms attached in Appendix H of the CoC's [Coordinated Entry Handbook](#).

Emergency Transfers for non-VAWA eligible households participating in RRH or PSH shall take the following factors into consideration:

- Ongoing emergency safety concerns for the program participant should an internal or external emergency transfer not be effected as soon as possible;
- The availability of openings to make an internal program transfer;
- The availability of openings to make an external program transfer, in the event an internal transfer is not immediately available; and
- Whether there are other available and adequate housing options and/or resources to ensure the safety of the program participant.

Recipients and subrecipients accepting program participants from other PSH or RRH projects must keep records on file demonstrating that the individual or family is: (1) transferring from another PSH or RRH project; (2) the reason for the transfer; and (3) that the individual or family met the eligibility requirements for PSH or RRH at the time they entered the original PSH or RRH project.

IV. Veterans

All Veterans are first referred to Supportive Services for Veteran Families (SSVF). SSVF will assess their needs and see if they need RRH, PSH, or VASH. The SSVF providers will enroll and house those Veterans whose assessment indicates that their need is only for RRH. If the Veteran is eligible for and selected to receive a VASH voucher, the Veteran will work with their VA caseworker who assists with the housing search and housing process. Veterans waiting on VASH vouchers can be housed in GPD beds while they wait on their voucher (if beds are available), or other ES or TH housing resources. CoC RRH and/or PSH will be prioritized for Veterans who are not eligible for SSVF or VASH. Other Literally Homeless Clients Seeking Services through Coordinated Entry that are not part of the Four Major HUD Homeless Populations (Chronic, Veteran, Family, or Youth) Referrals to mainstream programs will be made to clients indicating low acuity and shorter lengths of time homeless.

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Standards of Care, Section 4: Permanent Supportive Housing (PSH)

Goal: Assist clients with disabling conditions to maintain housing with a low-barrier, housing first approach.

Case Management includes:

- Assisting the client with transportation needs related to the service plan
- Assisting the client to make appointments and keep appointments, including providing transportation and accompanying the client if needed.
- Negotiation with landlords
- Problem solving and negotiations with client and neighbors
- Visit the client in their housing unit at least once each month. This visit provides an important opportunity to observe the client and their housing unit to identify any significant changes in behavior, or problems with the housing unit, that may jeopardize the clients housing stability.
- Client assessment is conducted at least once each month and more often as needed.
- Case management supervision (including case conferencing) occurs no less than two times each month.

Client goals are updated at least once each year.

These goals are integrated into the service plan which addresses three primary needs:

- **Housing and Basic Needs**
 - What it means to follow the lease: clean apartment, good neighbor, unit maintenance, rental payment
 - Income through SSI or employment
 - Mainstream benefits including insurance, SNAP
 - Food, money management
- **Physical Health**
 - May include food and dr. appointments
- **Mental Health**
 - Personal well-being and happiness (which may include volunteer activities, relationships, and community integration).

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Standards of Care, Section 5: CoC Chronic Homeless Documentation Standard

HUD has established documentation standards for chronic homelessness in the final rule defining Chronically Homeless (24 CFR 91 and 578) published December 4, 2015 and provides further information in Notice CPD-14-012 “Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status” and the Frequently asked Questions on Notice CPD-14-04-012.

The CoC shall follow HUD’s guidance which places greater emphasis on homeless documentation that is verifiable from homeless providers while allowing a portion of documentation to come from self-certification.

All documentation shall contain:

- date of the documentation
- client name
- date(s) homelessness is verified
- location of where the person slept
- contact information for the person signing the document
- signature(s)

Documentation Level:

Level	Source	Details	Minimum/Maximum
1.	Emergency Shelter Street Outreach	HMIS printout or signed verification on agency letterhead. Certification statement “I believe this person is homeless because I witnessed them sleeping in a place not meant for habitation at night or early morning.” (outreach)	At least 50% of total months. (6 of 12)
2.	Independent Third Party	Dated letter with signature With certification of person submitting the letter that they believe it to be true Certification that the client was observed in the uninhabitable location at night or early morning.	No more than 25% of total months (3 of 12)
3.	Client Self-Certification	Dated with client signature With certification of person submitting the letter that they believe it to be true.	No more than 25% of total months (3 of 12)

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Chronic homeless documentation shall consist of no less than 50% of total months homeless from Level 1 documentation (from emergency shelter or street outreach); no more than 25% months homeless consisting of Level 2 documentation (Independent Third Party); and no more than 25% of months homeless from Self Certification.

All attempts shall be made to obtain all homeless documentation (100%) from emergency shelter and street outreach staff. Navigators should document all efforts made to obtain Level 1 documentation while actively assisting the client to quickly obtain housing.

Navigators can request an exception for clients who are extremely vulnerable with high acuity. This exception request can be made to the Director of CoC Programs or the UNITY Executive Director for acceptance of chronic homeless documentation and prioritization for CoC funded PSH.

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Standards of Care, Section 6: Transfer for Clients from One Permanent Housing Program to Another

Basis: The HEARTH Act allows clients to transfer from one permanent housing program to another to better meet the service needs of the program participant as long as the client met the eligibility requirements for the second program prior to entering the first program. Transfers between programs of the same type and service level should be rare. However, such transfers may be needed to accommodate clients who need to transfer due to domestic violence.

Clients in need of PSH should be referred to PSH if there are openings available. If there are no openings, RRH may be used as a bridge to PSH. Clients in RRH may also be referred to PSH if a reassessment of service needs (and VI-SPDAT) indicate a need for PSH.

I. Types of Transfers

- a. PSH to PSH
- b. RRH to RRH – change in family composition requiring a change in program or due to a program that will cease operations or run out of funding.
- c. RRH to PSH – bridge or through a reassessment of service needs

II. Determination of Need to Transfer

a. Program Is Ending (Being Discontinued)

No less than 90 days before the end of the project, the program shall conduct the following steps to ensure clients maintain stable, permanent housing:

1. Clients are reassessed to determine the ongoing need for housing and services and whether the client should be transferred to a similar level of care.
2. The following documentation is submitted to the CoC Coordinated Entry team with recommendations for the type of program to be transferred to (PSH, RRH, Senior Housing, etc.): Client eligibility documentation, rental assistance documentation, and reassessment documentation.
3. The Coordinated Entry Team will determine availability of programs for clients to transfer into and submit a plan to the Director of CoC Programs.
4. Upon approval, client files will be copied and submitted to the new programs. A timeline will be developed to ensure there is no duplication in services or rental assistance.
5. The original program will conduct a “warm handoff” to introduce clients to new program staff.
6. HMIS shall reflect an exit to another CoC permanent housing program.
7. HMIS in the new program shall reflect entry from another CoC permanent housing program.

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b. Change in client eligibility

Some CoC programs may limit enrollment to a specific subpopulation as indicated in the project description through which the project was funded. In the event that the household composition makes the current client ineligible for the program, the program should first request from the CoC an exception to continue to serve the client.

c. Change in Client Service Needs - RRH to PSH

In some cases, a client is being served in RRH but a reassessment indicates a need for long-term PSH rather than RRH. It is challenging to then determine acuity of a client who is housed to determine prioritization for PSH program compared to a client who is unhoused. For consideration of a transfer to PSH, the program shall submit to the CoC Coordinated Entry Team:

1. Original VI-SPDAT score and total time homeless prior to program entry
2. Documentation of Disabling Condition and “In Need of Supports”
3. RRH reassessment information and new VI-SPDAT
4. Client eligibility documentation from program entry
5. Rental assistance documentation
6. The Coordinated Entry Team will determine availability of programs for clients to transfer into and submit a plan to the Director of CoC Programs.
7. Upon approval, client files will be copied and submitted to the new programs. A timeline will be developed to ensure there is no duplication in services or rental assistance.
8. The original program will conduct a “warm handoff” to introduce clients to new program staff.

d. RRH as a bridge to PSH

Clients in need of PSH should be referred to PSH rather than RRH. However, if there is not a PSH spot available, the client may be referred to RRH to be housed temporarily until a PSH spot is available. In some cases, RRH may be used as a bridge if the client is extremely vulnerable but lacks the documentation for PSH. When making these referrals to RRH, the client shall remain on the Master/By Name List while in RRH until they are transferred to PSH. The RRH program must still conduct reassessments of these clients and provide supportive services until the client is completely transferred to the PSH program.

1. Client eligibility documentation from program entry
2. Rental assistance documentation

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3. The Coordinated Entry Team will determine availability of programs for clients to transfer into and submit a plan to the Director of CoC Programs.
4. Upon approval, client files will be copied and submitted to the new programs. A timeline will be developed to ensure there is no duplication in services or rental assistance.
5. The original program will conduct a “warm handoff” to introduce clients to new program staff.

e. PSH to PSH

Transfer from one PSH program to another PSH program should be rare. Clients should not be encouraged to transfer. Priority shall be made for clients who are facing discharge from facility based/congregate programs to transfer to a rental assistance program. Clients facing eviction by independent landlords shall continue to receive PSH services by the original program and rehoused in the same program.

1. **Transfer initiated by Client:** Clients should first use the grievance and appeal policy of their original program to rectify any concerns. The client may then appeal to UNITY of Greater New Orleans. The client may appeal directly to Coordinated Entry Staff in cases where the client is in crisis.

The follow reasons for client requests will be considered:

- From facility based program to scattered site program which may offer greater independence for a client who still needs supports
 - Client has continued conflict with staff and other clients in the program
 - Client is in a facility based program and is in a unit that has failed HQS inspections.
 - Decline in client health indicating a different provider may better serve the client
 - Client grievance cannot be resolved in the existing program.
 - Domestic violence situation requires the client to move outside of the service area of their existing program.
2. **Transfer initiated by the Program Director:** The transfer request should be submitted to the Director of Coordinated Entry and the Director of CoC programs with the following information:
 - Reason for transfer to better provide services for the client.

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- Efforts made to provide services for the client including: training for staff regarding how to prevent escalation and prevent threatening behavior, accommodations for a client, establishing a representative payee for the client to make rent payments.
- Rationale for the program to continue to receive CoC funding despite being unable to serve this client.

Basis for Transfer will be considered for the following reasons:

- Domestic violence
- Unfair treatment by program staff
- Client's history of trauma indicates need for services from a different provider
- Direct threats from a client who also has a history of violence
- Eviction from a facility based program for approved reasons – threat to the community, non-payment of rent
- Domestic violence situation requires the client to move outside of the service area of their existing program.

Basis of transfer will NOT be considered for the following reasons:

- Client makes complaint to staff, supervisors, UNITY, or organization board
- Eviction by an independent landlord
- Client is not engaged in services
- Client no longer has Medicaid which is the basis for their services in the program

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Standards of Care, Section 7: New Orleans Interagency Council on Homelessness (NOICH) Standards of Care To Guide Provision of Housing and Housing-related Services

The New Orleans Interagency Council on Homelessness (NOICH) convened a Services Committee to examine the efficacy and coordination of service delivery across multiple service systems in 2012 and 2013 in an effort to improve the quality of services available to homeless people in the City of New Orleans.

The committee was charged to:

- Develop Common Standards of Care;
- Develop Training Curriculum for providers; and
- Develop a strategy for implementation of Centralized or Coordinated Assessment system.

The purpose of the council’s “Standards of Care To Guide Provision of Housing and Housing-related Services,” attached here, is to provide clear expectations on the minimum level of services all agencies must provide to clients. The standards are also designed to create consistency across agencies.

To the extent that the “Standards of Care To Guide Provision of Housing and Housing-related Services” as presented to NOICH in February 2013 do not conflict with the CoC’s Written Standards and guidance from HUD, they are incorporated into the CoC’s Written Standards.