Attachment F

Scope of Work – Access, Assessment, Navigation, and/or Housing Case Management

Note: Check and initial the box next to the function(s) that your agency will perform as a participating entity of the Coordinated Entry System (CES.)

☐ **Access Point** _____(initials)

Access Points serve as engagement points for persons experiencing a housing crisis, aimed at ensuring that all people in the community have equal access to all crisis response system resources in the CoC. Access points play a critical role in beginning to determine which intervention might be most appropriate to rapidly connect people to housing. Access points include Street Outreach teams and Emergency Service providers such as prevention, DV, crisis hotlines, drop-in services, shelters, and other short-term assistance programs.

As an Access Point participating in our community's CES, agency agrees to

1. Use the CoC's standard Assessment process, detailed in Assessment section below.
2. Not discriminate on the basis of race, color, national origin, religion, sex, age, familial status, marital status, handicap, actual or perceived sexual orientation, or gender identity.
3. Ensure the safety of persons who are fleeing or attempting to flee intimate partner violence, sexual assault, trafficking, or stalking through safety planning efforts. This could include calling a crisis hotline with the person seeking assistance so they may receive safety planning supports from crisis shelter staff.
4. Ensure adequate privacy protections of personal information and data collected, as well as private space for assessments.
5. Ensure hours of operations and services provided are clearly advertised and posted in appropriate language(s) spoken in the community. (Ex: English, Spanish.)
6. Ensure building has accessibility for persons needing ramps.
7. Ensure staff working at access points attend trainings offered through the CoC, including CES Overview and Housing First, Diversion, Trauma Informed Care, Motivational Interviewing, LGBTQ+ Inclusivity, Race Equity, Safety Planning, etc.
8. Have at least one agency representative participate in relevant CoC meetings as needed, which may include Shelter Provider Meetings, CoC Planning Meetings, registry meetings, CoC Membership meetings, etc.

☐ **Assessment** _____(initials)

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 phases of the assessment into a single participant interaction. The various phased of an Assessment include:

- Initial triage: Identifying the nature of the crisis and ensuring person's immediate safety
- Creative Housing Solutions: Can occur as part of initial triage or separately; focused on helping the person to examine their resources and options other than entering or remaining in the 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.

☐ **Housing Navigation** _____(initials) (add addendum for each sub-population)

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 from the Full registry with the goal of navigating someone into supportive housing.

Once a person has been through the phased assessment (Diversion attempts, CoC Entry, VI-SPDAT) 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 based on their priority on the Full registry. Prioritization is based on length of homelessness and vulnerability per the VI-SPDAT score. (*During COVID-19, COVID risks are also factored into a person's overall vulnerability). Navigation assignments are made either in Registry Management meetings or offline via email. Housing Navigators follow up with participant to verify information provided during assessment, help obtain needed documents, and refer person into Supportive Housing.

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. Refine, clarify, and verify the person's history, barriers, goals and preferences to ensure an appropriate match to available programs or housing options is made.
8. Once doc ready, 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).
9. Once a participant is matched 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 unsheltered at the time of the referral

i. Within 30 days for RRH
ii. Within 90 days for PSH. Regular and ongoing efforts to locate participant may 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.

Date _____ Intials _____

☐ **Housing Case Management - Phase 1 of 2: Locating and Planning for Housing** _____(initials)

All Supportive Housing Programs participating with CES should anticipate referrals for high acuity participants. As such, caseloads should not exceed the recommended ratio per project type. PSH 1:15-18 and RRH 1:20-25. 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 from the CES approved registry.
3. Conduct first face-to-face meeting with participant and Navigator:
    a. Scattered site programs
        i. For persons residing in shelter at the time of referral, within 72 hours
        ii. For persons unsheltered at the time of the referral
            1. Within 30 days for RRH
            2. Within 90 days for PSH
    b. Single Site Programs:
        i. Conduct leasing application with participant and Navigator within 30 days of referral
        ii. Inform CES via email if leasing application was denied.
        iii. For approved applicants, CM coordinates lease up and Move In with Navigator and Participant.
4. 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.
5. Complete Program Intake and begin process of obtaining safe and stable housing.
    a. When needed, contact CES for emergency shelter referrals for unsheltered participants.

b. When appropriate and as funding allows, link participant to bridge housing until permanent housing is available

6. Begin Housing Stability Plan via Case Plan notes or other standard Housing Stability Planning tool.
   a. Ensure Housing Stability Plan incorporates barriers to housing, participant strengths, goals to obtaining and maintaining housing, and the participant's plan to meet goals.
   b. If using HMIS Case Plan notes to track Housing Stability Plan, note "HSP" at the start of the case note to distinguish the Housing Stability Plan from progress notes.
7. 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.
8. 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.

Date _____ Intials _____

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.

9. 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 that HSN is subsidizing, email HLT to update.
   c. If applicant is approved for unit that HSN is subsidizing the rent for, submit ticket to HLT to request an inspection.
   d. Once HLT has inspected the unit and confirms a lease can be signed, Case Manager submits tenant's first month rent calculation form to HLTFinance@hsncfl.org, with other information or 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.
   e. Case Manager coordinates a time to join participant for the lease signing. Case Manager must be present for lease signing.
   f. Review all lease components with tenant, focusing on tenant rights and responsibilities as well as landlord 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. Once a lease is signed, furnish copy of lease to HLTFinance@hsncfl.org within 3 business days of signing, if HSN is subsidizing rent.
   h. Upload signed lease in HMIS. If file is too big, include pages 1-2 and signature page.
10. Case Manager ensures Utilities are set up to begin the day of move in

Date _____ Intials _____

11. Case Manager arranges furniture and household goods for the day of move in, ensuring basic needs are in place
12. Case Manager is present at Move In to help orient tenant to unit (Move-Ins may be later than the lease signing)
    a. Fire extinguisher and emergency exits
    b. Maintenance activities to be done by tenant
    c. How and when to submit a maintenance request to landlord
    d. On/Off for all utilities (water valve, circuit breaker, etc.)
    e. Use of appliances
    f. Cleaning techniques for the surfaces in the unit (carpet vs. tile; wood vs paint)
13. Case Manager helps orient tenant to complex or neighborhood
    a. Designated smoking areas
    b. Where to get groceries
    c. Bus routes
    d. Parks and walking paths
    e. Social and Community Connections
14. Complete interim update in HMIS to reflect move-in date and new permanent housing address. Move in Date should reflect the first night the tenant slept in the unit, which may be a later day than when the lease was signed.

Date _____ Intials _____

☐ **Housing Stability Case Management - Phase 2 of 2: Supporting Housing Stability** _____(initials)

1. Update Housing Stability Plan with tenant, that may include but not limited to
    a. Housing Stability Goals (use SSOM or other tools to gauge service needs)
        i. Getting settled in housing
        ii. Work with tenant on a personal guest policy
        iii. 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.
        iv. 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
        v. 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
        vi. Transportation to:
            1. Medical or Behavioral Health appointments
            2. Employment
            3. Child-care/schools
            4. Groceries
            5. Support group meetings
        vii. Community and Social Integration - Offer supports to connect to faith groups, peer support groups, volunteering, voting, community gardens, events, community activities, etc.)
        viii. Increasing income – Case notes must include concrete steps for increasing income through applying for benefits or suitable employment
        ix. Work with tenant to develop disaster weather plans, if appropriate
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

Date _____ Intials _____