Prince William Area
Continuum of Care

Coordinated Entry System

FY26 Policies and Procedures Manual

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Section I – Introduction

Background

The Prince William Area (PWA) Continuum of Care (CoC) uses best practice models designed to prevent homelessness and to address homelessness for individuals, families, and subpopulations of homelessness (e.g. veterans, youth).

The CoC aligns with the federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. HEARTH has established goals and objectives aimed at ending chronic homelessness and reducing all homelessness. Additionally, all Coordinated Entry System (CES) processes align with HUD's Centralized Assessment System (CPD 17-01) released January 23, 2017. To achieve success, the CoC has aligned resources at the federal, state, and local levels with CPD 17-01 that include:

- Coverage of the geographic area (Prince William County and Cities of Manassas & Manassas Park).
- Easy accessibility for individuals and families seeking housing and/or services.
- Well-advertised prevention and homeless services.
- An initial standardized assessment of individuals and families seeking housing.
- A specific policy to guide the operation of the CES in addressing the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, and are seeking supportive services from non-victim specific providers.

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

Guiding Principles

The CoC members will use the following guiding principles to aid in the system's planning and design, implementation processes, and ongoing management of the CES 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 connect with the housing/services that best meet their needs.
- Ensure clarity, transparency, consistency, and accountability for homeless households, 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 households 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 consistent eligibility criteria and prioritization standards.
- Retain program flexibility to the extent possible.
- Ensure that all programs operate within compliance of all funding guidelines and eligibility criteria.
- 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 are trained and competent in conducting assessments.

The CES plays an essential role, and the data generated from CES 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.

Purpose

The purpose of the CES is to provide a coordinated process for households (individuals and families) to use when they believe they are at risk of becoming homeless or they are currently deemed homeless according to HUD's definition. Via the CES, a household can be screened for eligibility for specific housing options that include Prevention, Housing Case Management, Rapid Rehousing, Permanent Supportive Housing, and Emergency Shelter. The optimum goal of CES is to assess a household and then determine the intervention that best matches its unique needs.

Residency Introduction

The Prince William Area Continuum of Care (CoC) recognizes that funding received from state and federal sources may allow for services to be provided to residents of another jurisdiction. However, the Prince William Area CoC will prioritize households limited to residents of Prince William County and the cities of Manassas and Manassas Park.

Housing Options

The PWA has a goal to prevent homelessness whenever possible. Determining the feasibility of current housing or an assessment of available housing options must be made prior to placing a household in an emergency shelter. PWA seeks to 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, case managers will focus on affordable housing options that include rapid rehousing, permanent supportive housing, room rentals, and shared housing accommodations (living with relatives or friends).

Homeless Management Information System (HMIS)

The PWA Homeless Management Information System (HMIS) is the primary repository for CoC data and is a requirement for most federal, state, and local programs serving homeless persons. CES will utilize the HMIS to collect data about persons seeking services from any program dedicated to serving homeless households as well as those at risk of becoming homeless. The data obtained will be used to help guide the development of CES policies and better inform the CoC on how programs are performing. Performance outcomes for programs will be measured using HMIS data as well as other sources (such as financial records and client files).

Providers must complete data entry and reporting for HMIS where required in compliance with the current HUD HMIS Data Standards as well as the CoC's current HMIS Standard Policies & Operating Procedures manual.

Victim Service Providers (VSPs) (i.e., providers that serve domestic violence survivors) must use a comparable database that follows the current standards to complete data entry and reporting for their programs. VSPs are not permitted to utilize the "primary" HMIS due to provisions outlined in the Violence Against Women's Act (VAWA).

Providers should contact the CoC's HMIS Lead for more information on HMIS and comparable databases.

Low Barrier/Housing First

The PWA will use best practice models that include implementing low barriers for emergency shelter systems and implementing a Housing First model as it relates to housing options that are specific to Rapid Re-Housing (RRH) and Permanent Supportive Housing (PSH). Our shelter systems will strive to reduce all barriers to accessing emergency shelter, including criminal history. The PWA will also implement Housing First, a recovery-oriented approach to ending homelessness that centers on quickly moving people experiencing homelessness into independent and permanent housing and then providing additional supports and services as needed. The five core principles of Housing First include:

1. **Immediate access to permanent housing with no housing readiness requirements:** Housing First involves providing households with assistance in finding and obtaining safe, secure, and permanent housing as quickly as possible.
2. **Consumer choice and self-determination:** Housing First is a rights-based, client-centered approach that emphasizes client choice in terms of housing and support. Households exercise some choice regarding the location and type of housing they receive (e.g. neighborhood, congregate setting, scattered site, etc.). Choices may be constrained by local availability and affordability.

3. **Recovery orientation:** Housing First practice is not only focused on meeting basic client needs, but also on supporting recovery. A recovery orientation focuses on individual well-being and ensures that households have access to a range of supports that enable them to nurture and maintain social, recreational, educational, occupational, and vocational activities.
4. **Individualized and client-driven supports:** A client-driven approach recognizes that individuals are unique, and so are their needs. Once housed, some people will need minimum supports, while other people will need supports for the rest of their lives. This could range from case management to assertive community treatment. Individuals should be provided with "a range of treatment and support services that are voluntary, individualized, culturally appropriate, and portable".
5. **Social and community integration:** Part of the Housing First strategy is to help people integrate into their community, and this requires socially supportive engagement and the opportunity to participate in meaningful activities. If people are housed and become or remain socially isolated, the stability of their housing may be compromised.

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 does not, then 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:

- 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 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 homelessness 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 enough to stabilize housing in the community within a 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 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 do not 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 changes in resources or improved management of resources, over time the household can 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.

Community Case Conferencing

Households with ongoing housing needs face complex challenges. Often, comprehensive plans involving multiple stakeholders yield the best outcomes. Community case conferencing is a collaborative approach to discussing the progress of households enrolled in any homeless service programs who are having difficulty achieving service plan goals aimed at helping the household obtain or maintain stable housing. Individuals and families receiving prevention, diversion, emergencies, rapid re-housing, or permanent supportive housing services can be involved in community case conferencing. The program manager from each respective shelter will participate in community case conferencing. DSS Homeless services staff must be a part of all community case conference meetings.

When issues arise that involve program 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 program participants and staff should be outlined during your internal case conferences to include warning letters, behavioral contracts, or other documentation given to the clients. This plan should be in writing, it should include specific, measurable, attainable, realistic, and time specific (S.M.A.R.T) goals, that are clearly explained to all households. Households who have not engaged in services within the first 30 days should have their first internal case conference. The shelter providers will hold a minimum of two internal case conferences prior to submitting a request for a community case conference. Within the specified time set during the internal case conference, if the challenges have not been resolved, then make a referral via the HMIS system.

If a case conference is warranted, the case manager should do the following.

- Make a referral via the HMIS system.
- Upload the community case conference request form and supplemental documentation from the household record in HMIS.
- CES will schedule a case conference upon review and approval of all required documentation.
- The Human Services Manager will respond to the request with the date and time of the meeting.
- Submission of a case conference request does not guarantee an automatic community case conference meeting.
- Community case conferences will be held between 10:00am -12:00pm, on the 1st and 3rd Friday of each month. These meetings are held via WebEx.
- During the community case conference, the case manager will complete the case conference summary form to outline the actions steps from the meeting.
- If amenable to continued participation with services, the household and case manager will meet to review the expectations of the plan. An updated housing plan with measurable objectives will be created and the household will sign and receive a copy. If the household is still not compliant with the updated housing plan, the household may be discharged from the program based on the date outlined in the case conference meeting, and notification sent to CES.

- Households who are not in compliance with their housing plan are required to participate in a community case conference prior to shelter discharge.
- The case manager will upload the case conference summary form in HMIS along with all supporting documents (i.e., internal case conferences, non-compliance letters, housing stabilization plans, behavior contracts, and etc.)

Section II – Coordinated Entry System (CES)

Overview & Purpose

The purpose of this CES policies and procedures manual is to facilitate the management and delivery of homeless services in the PWA.

CES Mission Statement:

To create and operate a coordinated entry process that mutually empowers households and providers to **move households effectively and efficiently** to the best housing option based on their individual needs.

This policy and procedure manual serves as the source document detailing the CES. A key goal of the CES is to reduce new incidents of homelessness. The CES will provide a clear method by which persons at risk of becoming homeless can be assessed and determined eligible for housing programs within the CoC.

The CES **WILL:**

- Assess households for their strengths and work with the households 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 motel/hotel placement, emergency shelter, and case management services**.
- Match households to programs based on their assessed needs.

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

- Emergency Shelter.
- Rapid Re-Housing programs.
- Permanent Supportive Housing programs.
- Alternative Living Arrangements (joint living arrangements, room rental).

The CES **WILL NOT:**

- Create new housing in our system.
- Guarantee a placement in a housing program and/or financial rental assistance.
- Provide case management.

The CES 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.

- 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 (e.g., emergency shelter, rapid re-housing, and permanent supportive 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.
- **Referral policies and procedures** to guide the process from assessment of need to accessing assistance from homeless services providers.

Households To Be Served:

The CES will serve households with a critical housing need that places the household at risk of becoming homeless and who may have barriers that prolong their episode of homelessness. The following households are to be served: Individuals and families at risk of homelessness or experiencing a housing crisis currently residing in PWA.

HUD Definition of Imminently at risk of homelessness is a household who are losing their primary nighttime residence, which may include a motel or hotel or a doubled-up situation, within 14 days and lack resources or support networks to remain in housing.
The PWA works with eligible households to meet their housing needs regardless of race, color, religion, creed, sex, sexual orientation, pregnancy and pregnancy related conditions, gender identity, national origin, ancestry, age, veteran status, disability, genetic information, military service, or other protected statuses.

Procedures

The CES will streamline access to programs that aid households at risk of becoming homeless or those households that are literally homeless within the PWA. 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.
- Guiding Principles Hotel/Motel Services.
- Emergency Shelter Services.
- Rapid Re-Housing Services:
  - Short-term.
  - Medium-term.
  - Long-term.
- Permanent Supportive Housing.

CES is the First-Level Screening Service for CoC programs. This means CES conducts the initial screening, eligibility, and service matching, while the receiving program makes final admissions decisions.

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

Providers

The PWA CoC and the Lead Agency, Prince William County Department of Social Services (DSS), partner with agencies that provide prevention services, emergency shelter, rapid-re-housing, and permanent supportive housing.

Access to Services

The PWA CoC has chosen a coordinated call center model with one phone number to address calls specific to households at risk of becoming homeless and households currently homeless. The CES is available to households in crisis five days a week, Monday – Friday from 8:30am to 5:30pm. Households can start the assessment process by calling 703-792-3366 to talk with a staff person during operating hours.

At the conclusion of an intake call, households will be informed of the appropriate documentation that will be needed in order to qualify for various programs within the CoC. The Human Services Specialist will complete intake screening via the HMIS System and make a referral to an identified program to address the housing crisis and needs.

After Hours and Holiday Procedure:

The CES recognizes that a household emergency may not take place during regular business hours. Emergency needs can arise after hours. For any household that calls after hours, they will have the ability to leave a voicemail message, and a Human Services Specialist will call back within a 24-hour period during the next business day. After hours, households can go directly to the emergency shelter and the shelter provider will temporarily accept households into an emergency shelter program. The next business day, the program will connect the household to CES for an assessment.

Practice diversion (even if there is a bed available) and if diversion is not an option, follow the steps outlined under Sex Offender Registry for temporarily accepting the household into the shelter.

Sex Offender Registry

A sex offender registry check is to be completed on all adults (18 years old and older) entering a shelter. To do this, go to the link below and search for the individual by entering the first and last name. **Please remember we are low barrier – therefore we only search for sex offenders. **

Link: https://www.nsopw.gov/

- If a record is found, inform the individual that they cannot enter a shelter and they will have to find other alternative arrangements. If during the hypothermia season during days hypothermia is in place, please refer clients to the hypothermia program.

- If no record is found, review terms of the emergency overnight stay. Ensure **Emergency Overnight Contract** is signed by head of household.
- Complete the **Emergency Overnight Intake Form** and email it to CES the next business day at DSSCE@pwcgov.org.
- Instruct the household to contact CES the next business day.

After Hours Emergency Shelter Procedure

CES will process and approve referrals to Emergency Shelter during CES business hours. However, when after hours, shelter providers may be able to temporarily accept households into their program until an opportunity to connect with CES becomes available.

- Shelter providers should attempt diversion for the household to find a safe space to stay for the night if possible. If entities (such as hospitals, mental health facilities, jails, etc.) attempt to "drop off" someone after hours, they will be sent back to place of origin if possible. If from out of county/state, providers will attempt to connect with shelters in original jurisdiction for shelter there or a safe place to stay in that county/state.

Single Adults (Has Space)

If the shelter has an open bed for emergency placement, provider will complete the process for an after-hours shelter stay including entering them into HMIS and uploading the after-hours Intake documents. Shelter providers will work with the household to ensure they meet the shelter eligibility criteria and must ensure the household calls CES the next open business day. CES will complete an assessment with the household. CES will work with the provider to determine next steps for the household.

Single Adults (No Space)

1) If the shelter has no space available, they will contact other CoC shelters to check for bed availability.
2) If no other shelter space available in COC, providers would try their best to coordinate a safe place for that person to go to as the best of their ability. This could mean contacting APS or hypothermia to provide temporary shelter.

3) If none of the options are available and the shelter can put the household in an overflow space at the shelter, they will be assessed based on vulnerability such as health, pregnancy, elderly or youth. If they do not meet these criteria, or there is no overflow space available, then the shelter provider will not be able to serve them, and they should be instructed to contact CES during business hours the next day they are open.

Families (Has Space)

If the shelter has an open room (beds) for emergency placement, provider will complete the process for an after-hours shelter stay including entering them into HMIS and uploading the after-Hours Intake documents. Providers are responsible for ensuring the household meets shelter eligibility criteria and must ensure the household calls CES the next open business day. CES will complete an assessment with the household. CES will work with the provider to determine the next steps for the household.

Families (No Space)

1) If the shelter has no space available, they will contact other COC shelters to check for bed availability.

2) If none of the options are available and the shelter can put the household in an overflow space at the shelter, they will be assessed based on vulnerability such as health, pregnancy, elderly or youth. If they do not meet these criteria or there is no overflow space available, then the shelter provider will not be able to serve them, and they should be instructed to contact CES during business hours the next day they are open, and the shelter provider will contact Child Protective Services (CPS) prevention if the household cannot be diverted at that time.

Screening/ Assessment:

The CES is the main entity responsible for ensuring that all households experiencing homelessness and at-risk of homelessness are promptly screened and assessed.

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

- **Complete an Initial Assessment: A** Human Services Specialist will assess the household's needs and identify the appropriate level of housing and/or support needed. For any households referred to a program, they will be informed of the required documentation needed for that program.
- **Prevention:** If Prevention is identified as a need, the household will be referred to the CoC prevention providers via HMIS and the household will be given the contact number to call to follow up regarding eligibility for services.
- **Diversion: If** Diversion is identified as a viable option to shelter, the household will discuss it with a Human Services Specialist.
    - (1) if the current housing can be successfully maintained or
    - (2) if another housing option (e.g. living with relatives friends, family) is plausible.
- **Emergency Shelter: If** there is temporary shelter space available and the household cannot be diverted, the shelter provider and the client will contact CES on the next business day.
- Households with a minor child under the age of 18 - If there is not an available shelter space for a household with a minor child under the age of 18 the shelter provider will contact child protective services prevention.
- Single adult – if there is not a temporary shelter space available and the single cannot be diverted, during the hypothermia season from November 1 – March 31, the single can be referred to the hypothermia program.

Documentation

Additional documentation may be requested from households seeking prevention assistance and supportive services. Households may be required to provide the following documentation:

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

- Households seeking access to emergency shelter, diversion services, and/or rapid re-housing must provide Proof of Homelessness (letter from current provider or relative, or information gathered from the HMIS system) and documentation of imminent eviction from housing.

Vacancy Tracking

CES is responsible for tracking all aspects of the coordinated system. Therefore, it is imperative that CES track placements and exits of households into and from programs to know the availability of housing and service options.

The Service Continuum Committee through the CES will manage a centralized vacancy tracking system for all the following programs.

- Emergency Shelter

The CES/Services Continuum Committee 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.

CES will use HMIS to manage the vacancy tracking system. Programs will be required to post vacancies for designated beds in HMIS within twenty-four hours of unit/bed availability. If providers know of an impending vacancy, they are required to post the anticipated availability date within two business days of being made aware of such availability and update HMIS with the actual availability date once the bed becomes vacant. Programs must update vacancy information in HMIS within twenty-four hours of a unit/bed being filled.

Categories of Homelessness & Chronically Homelessness Definition

Category 1: Literally Homeless	Persons who are living in a place not meant for human habitation or emergency shelter (including hotel/motels paid for with Emergency Shelter vouchers) for any length of time OR 1a. Have been in a temporary/permanent housing situation for less than 7 nights and were sleeping on the streets or in shelter the night prior to entering said housing situation OR 1b. Have been in an institutional setting for less than 90 days and were sleeping on the streets or in shelter the night prior to entering said institution 1b2. There are 6 types of institutional settings: 1. Foster care home or foster care group home 2. Hospital or other non-psychiatric residential medical facility 3. Jails, prisons or juvenile detention facilities 4. Long-term care facilities or nursing homes 5. Psychiatric hospital or other psychiatric facilities 6. Substance abuse treatment facilities or detox centers
Category 2: Imminent Risk of Homelessness	Persons who will lose their primary nighttime residence within 14 days and lack the resources or support networks to remain in housing

	2a. Primary nighttime residences include hotels/motels and "doubled-up" situations (e.g. "couch surfing")
Category 3: Homeless Under Federal Statue	Families with children or unaccompanied youth who are in unstable housing and are likely to continue in that state 3a. This definition includes homeless youth as defined under federal statutes 3b. Unstable housing is defined by: 3b1. Not having a lease or ownership in a housing unit in the past 60 days AND 3b2. Having 2 or more moves in the past 60 days AND 3b3. The likelihood of remaining unstably housed due to disability or multiple barriers to employment
Category 4: Fleeing/Attempting to Flee Domestic Violence	Individuals or households fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, life-threatening situations related to violence and who also lack the resources or support networks to secure new housing. **VAWA 2022 Amended McKinney-Vento Definition of Homelessness Category 4 Definition** Any individual or family who • Is experiencing trauma or a lack of safety related to, or fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic, or life-threatening condition • related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety of children are jeopardized • Has no other safe residence, and • Lacks the resources to obtain other safe permanent housing.
Chronically Homeless	A single individual or head of household of a family with a diagnosable disability and a long-term history of literal homelessness 5a. Specifically, a chronically homeless person must have a diagnosable disability AND live in a place not meant for human habitation or emergency shelter: 5a1. Continuously for at least 12 months without any breaks OR 5a2. On four or more occasions in the past three years where the combined occasions total at least 12 months The four or more occasions must be divided by "breaks" as described below 5b. A break in homelessness is considered when: 5b1. A person enters a temporary or permanent housing situation; where they were previously on the streets or in shelter; and remains in said situation for more than 7 nights 5b2. A person enters an institutional situation; where they were previously on the streets or in shelter; and remains in said situation for more than 90 days.

Prioritization

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

- Prevention eviction services.
- Diversion services.
- Case Management services through housing programs.

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

- Rapid re-housing.
- Permanent Supportive Housing
- Other Permanent Housing Options.

Referrals

Preliminary eligibility for all programs will be determined by CES according to standards set forth by the CoC as well as program funding requirements. CES will complete an assessment with households seeking services to determine their level of need and eligibility. Program referrals will be made to or by CES dependent on the situation and program type. The referrals will be processed through the HMIS system with additional conversations taking place by phone or email as needed. CES may make referrals outside of HMIS to other "community-based" organizations based on the CoC's current resource list.

CES will complete outgoing referrals within one business day (at the time of the call) is responsible for ensuring information and documentation is complete and accurate based on information collected from the head of household. Providers should follow-up with CES if referrals are incomplete. Providers must respond to incoming referrals in accordance with the timeframe outlined under each program.

CES will create referrals in HMIS for different services as needed.
Referrals will not be accepted until all information and documentation is complete and accurate. Providers are responsible for ensuring referrals are complete prior to submission to CES. Providers may not admit households to homeless programs without prior approval from CES.

Providers will create referrals in HMIS for the following programs:

- Community Case Conferences
- Permanent Housing
    - Permanent Supportive Housing
    - Rapid Re-Housing

After Hours Procedure for Emergency Shelter:

CES will process and approve referrals to Emergency Shelter. However, when after hours, shelter providers can temporarily accept households into their program until an opportunity to connect with CES becomes available. CES will work with the provider to determine next steps for the household.

Shelter providers working with a homeless household after hours may not have space available. If this is the case, the shelter provider should contact other CoC shelters to check for bed availability. Shelter providers should work together to serve the household and provide temporary housing.

Section III – Prevention

Overview & Purpose

When housed applicants are experiencing housing crisis, CES process will assess the household and determine the appropriate program the household may qualify for to become a program participant. Prince William County established **the Rental Utility Assistance Program (RUAP**) to address short term crisis for households at risk of homelessness. For households imminent risk for homelessness at 30% AMI, and in need of ongoing support, **Virginia Homeless Solutions Program (VHSP)** allows households to receive case management for stabilization. Prioritization for this program The **Emergency Food and Shelter Program (EFSP)** is a FEMA-funded program authorized by the McKinney-Vento Homeless Assistance Act of 1987. The program supplements and expands ongoing work of local nonprofit and governmental social service organizations to provide shelter, food and supportive services to individuals and families who are experiencing, or at risk of experiencing, hunger and/or homelessness.

Households will be prioritized by their conditions and housing risk level presented at screening. When slots are released, CES staff will screen households and add to a housing crisis prioritization list. Households will be referred to by following Friday of the release of slots. If a client has a writ of possession, CES Human Services Manager and funder will be notified immediately.

After CES makes their initial assessment, they will submit a referral through HMIS to prevention services. If accepted by prevention service, the program will decide the minimum amount and duration of assistance needed to achieve housing stability. If it becomes clear at a later date that the amount and/or duration are not enough, the household will be reassessed by the prevention program currently working with them, and the amount and duration of assistance may be adjusted by the prevention provider. Participating households may be recertified at three-month intervals throughout their program participation. The guiding principle for all Prevention funds is: If not for the financial assistance intervention, the household would be literally homeless.

If it becomes clear at a later date that the amount and/or duration are not enough, the household will be reassessed by the prevention program currently working with them, and the amount and duration of assistance may be adjusted by the prevention provider. Typically, participating households are recertified at three-month intervals throughout their program participation. The guiding principle for all Prevention funds is: If not for the financial assistance intervention, the household would be literally homeless.

The PWA has three categories of prevention assistance to meet the needs of households at risk of becoming homeless. Please reference Table 3.1 for specific policies and procedures concerning Prevention Services.

Table 3.1 – Prevention Assistance Program Types

Category 1	**One-Time Rental Assistance/Short-Term**	Designed for households in which a temporary set-back occurred (e.g., 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 to two 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 month's 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 will require financial assistance coupled with case management stabilization services. **Length of time:** Three to six months of overall assistance. The financial assistance can cover a portion of the rent. The determination of how financial assistance is provided depends on the Housing Plan (HP) drafted by the case manager and household. The rental assistance can be stepped down in nature (gradual decrease in the amount of funding provided over a period of time).
Category 3	**Intensive Case Management Services/Long-Term**	Program is designed to assist households that appear to need intensive case management services in the home. Financial assistance exceeds six 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 to twelve months of overall assistance. Financial assistance can cover a portion of the rent. The determination of how financial assistance is provided depends on the Housing Plan (HP) drafted by the case manager and household. The rental assistance can be stepped down in nature (gradual decrease in the amount of funding provided over a period of time).

Households Accessing Prevention Services

Prevention services are designed to work with households that, after completion of the intake paperwork, demonstrate that 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 assessment by CES and/or the provider.

Procedures

To access Prevention Services the following procedures will be followed.

- CES will complete the assessment. Upon completing the assessment, if it appears that the household needs prevention services, CES Staff will submit a referral to the partnering agency via HMIS.
- Upon the referral being made, the Human Services Specialist will inform the household of basic information that it may be required to include:
    - A copy of lease and utility bill with head of household name.
    - A valid photo identification or other documents needed when meeting with the prevention provider.
- The CE staff will also be provided a specific point of contact, including phone number, physical address, and email.
- An email detailing this information can be sent to all households seeking prevention services if requested.
- The partnering agency may review the referral request and clarify questions with the CES.
- If the prevention program accepts the household, then the program will complete all the necessary paperwork and assessments and develop a housing plan for the household.

Providers

Prevention Services can be provided by non-profits, faith-based organizations, outreach providers, or other local entities.

Screening/Assessment

The CES 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 housing crisis (e.g., Impending Court Eviction, Late Notice, 5 Day Pay or Quit, etc.), the following steps will be taken:

- **Assessment:** A Human Services Specialist will determine the household's needs and identify the projected level of prevention. Households will be required to provide supporting documentation to the referring agency 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 Human Services Specialist will submit a referral to the receiving agency.

Documentation

All households will provide the following.

- Proof of Income (paystubs, SSI or SSDI 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 (Eviction notice from Court, 5 Day Pay or Quit, Late Notice, etc.).
- Copy of current lease.

Financial Resource Tracking

DSS in conjunction with the PAR committee will monitor expenditure of financial assistance by state-funded programs only in order to assess the availability of resources on an on-going basis and to prevent unexpected or rapid depletion of resources. Quarterly meetings will be held with all Partnering Agencies receiving state prevention funding to review program and financial data.

Prioritization

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

Referrals

Determination for Prevention Services will be initially made by CES based upon the assessment. Therefore, referrals for prevention funds and services will be made by CES to the respective program. The referrals will take place via the HMIS system and/or email, and additional conversations will take place by phone. The CES will make the referral through HMIS indicating the need for prevention services to the appropriate agency. Prevention programs funded with state funds may only accept households into their programs based on referrals made by the CES. Providers will respond to the referral within the HMIS system and attempt their first contact with the household within three (3) business days of receipt. Providers must attempt at least three (3) contacts with the household within seven (7) business days before closing the referral.

Re-certifications

Households receiving Prevention assistance (state funded only) 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 using progressive engagement and clearly conveyed to household. If the household no longer meets program eligibility at the time of re-certification, shelter will provide referrals to other services, if needed, and follow procedures to close the case.

Program Acceptance Notification

All households accepted to Prevention services (state funded) 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 to a person other than the person (or a subordinate of that person) who made or approved the termination decision.
(3) Prompt written notice of the final decision to the program participant, and
(4) Document the outcome via the HMIS system.

Closure Notification

All households being closed to program services regardless of the reason, must be provided a program closure letter noting the exact closure date, reasons for closure and the grievance policy related to the case closure. Partner Agencies must document outcomes via the HMIS system.

Section IV – 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.

The PWA Diversion program can:

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

Diversion programs can also help the PWA community achieve better outcomes and be more competitive when applying for federal and state 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 CES (responsible for

conducting initial intakes for households). All households seeking shelter or at imminent risk of homelessness will receive an initial assessment to determine the need and best intervention for the current housing situation.

Households To Be Served

Within PWA, any household (individual or family) seeking to access emergency shelter will be eligible to meet with the Human Services Specialist who can 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.

- A Human Services Specialist will complete the Initial Assessment.
- If it appears that the household may benefit from Diversion Services, the household will be enrolled in the Diversion Service program.
- The Human Services Specialist will work with the household to identify housing options to include family, friends, co-workers, and other natural supports.
- The Human Services Specialist will complete any additional assessment if necessary.
- The Human Services Specialist will document the information in the HMIS record.

Providers

Diversion begins at the Coordinated Entry System; however, emergency shelters will continue to work with households to quickly resolve their homelessness.

Screening/Assessment

The initial 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 will conduct the Initial assessment. These households must be assessed via the CES.

Documentation

There is no specific documentation needed for Diversion Services. However, a conversation does need to take place with the Human Services Specialist.

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.

Section V – Emergency Shelter

Overview & Purpose

CES will complete an assessment with households that request access to emergency shelter. However, priority is given to Prince William Area residents, including Prince William County and the cities of Manassas and Manassas Park. Emergency shelter is reserved for households that appear to meet the US Department of Housing and Urban Development (HUD) definition of homelessness. Additionally, the household appears to have no other viable living arrangements or housing options.

CES serves as the first screening level and works with the emergency shelter providers to make the final admission decision. The possible eligibility for each service will be made by CES based upon the intake/assessment completed. Therefore, referrals for emergency shelter will be made by CES to the respective programs. The referrals will take place via the HMIS system and additional conversations will take place by phone.

CES is responsible for several aspects of the coordinated system. Therefore, CES will track entries and exits to emergency shelter. All shelter providers will routinely update the emergency shelter bed lists. CES Human Services Specialist will routinely check the HMIS bed list for availability.
Please note that "Emergency Shelter" includes hotel/motel stays paid for using CoC or other community funds.

Households to Be Served

If the household cannot be diverted, a referral for emergency shelter will be made to one of the emergency shelter providers. All households meeting the HUD definition of homelessness, and with no other viable housing options, will be referred.

Hypothermia Shelter

During the winter season, it is important to ensure the safety and well-being of individuals who may be at risk of hypothermia. Hypothermia shelter services will be provided in the Prince William Area from November 1st to March 31st. These services aim to prevent the loss of life or limb due to extreme cold weather conditions.

These services are for adults aged 18 and older in the community who are experiencing a housing crisis resulting in homelessness. The shelter provides a warm indoor sleeping environment, meals, shower facilities and information on other community and county resources.

- For households with minor children, please contact the Coordinated Entry System (CES)during operation hours at 703-792-3366.
- Individuals must be able to perform their daily living activities (such as walking, dressing, bathing, use of restroom, and eating) without assistance.

Procedures:

Hypothermia services will be provided in the Prince William Area including the East, West, cities of Manassas and Manassas Park. A limited number of single adults will be assisted on a first-come, first-served basis. There is no referral process for this shelter.

All shelter providers operate under a low barrier policy which means no individual will be excluded from shelter due to substance abuse history, criminal history, or previous history with any shelter provider. Shelter providers do not conduct any additional background checks for shelter admission.

Screening/ Assessment/Documentation
Questions are asked at intake, but no documentation and verification are required to prove homelessness. Possible diversion options are discussed at intake and during the stay at the hypothermia shelter. Due to hypothermia services being a lifesaving program, guests do not have to meet the PWA residency requirements for eligibility.

CES Overall Role

- Send out hypothermia services notifications to providers two times per week (Sundays & Thursdays).
- Provide information about hypothermia services. CES will encourage clients and providers to call the hypothermia programs during their operating hours for more information or available space.

Termination and Discharge Procedures
Upon entry into the hypothermia shelter, individuals must receive written notification of the provider's grievance policy. The grievance policy must provide specific procedures to be followed for any disputed shelter decision impacting the individual's shelter stay.
An individual may be terminated from the hypothermia shelter for one or more nights, including the entire season, if the individual engages in behavior that affects the safety and security of other shelter guests, or violates any other rules and regulations. In this case, the provider will give the guest written notice of the violation and terms of the discharge.
Appeals: Terminations may be appealed according to the grievance procedure set forth by each provider. The Hypothermia shelter staff will make every effort to work with difficult guests or guests who have been banned from other shelters due to the potentially cold and hazardous weather conditions.
Provider-specific contact information, further details, and training about the upcoming hypothermia season will be available for the community closer to the start of the program.

Prince William Area Residency Policy

The Prince William Area Continuum of Care (CoC) recognizes that funding received from state and federal sources may allow for services to be provided to residents of another jurisdiction. However, the Prince William Area CoC will prioritize households comprised of residents of Prince William County and the cities of Manassas and Manassas Park.

Households that are seeking to obtain **Emergency Shelter services**, the households must provide two (2) the following proof of residency within (seven) 7 calendar days of entering the Emergency Shelter.

- **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 Prince William County School:** A family household should provide verification that their school aged children are currently enrolled in a Prince William County, Manassas Park or City of Manassas school. The children should have documented enrollment in school for 30 days prior to seeking emergency assistance.
- **Verified current Lease:** An adult member(s) of a household should provide a copy of a lease from a property physically located in Prince William County, Manassas Park or City of Manassas. 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.
- **Utility bill dated:** An adult member(s) of a household should provide a copy of a current bill from the utility company that provides the name of at least one adult person of the household and the current Prince William County, Manassas Park or City of Manassas, address at which the utility bill charges were incurred.
- **Payroll statement:** An adult member(s) of the household should provide a copy of a payroll statement from their current employer or of the last employer within 30 days. The payroll statement should include the name of the adult(s) and the current address provided to the employer.
- **Disability Verification Letter:** An adult member(s) of a household should provide a copy of the eligibility letter from Social Security Disability Income. The letter must include the name of recipient and a Prince William County, Manassas Park or City of Manassas address.
- **Documented connection to local services:** An adult member(s) of the household should provide documentation that they are currently connected to Prince William County, Manassas Park or City of Manassas homeless outreach provider for the past 30 days. The client can also show documentation from their Behavioral Healthcare outpatient therapist that shows connection to services for the past 30 days as well as verification of where they have been staying in Prince William Count, Manassas Park or City of Manassas to receive services.

For homeless households currently **residing on the streets** and meeting the Federal definition of literally 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 (e.g., state ID) to be identified as a Prince William County resident.
- **Inability to meet residency standards (Outreach):** If the household is unable to provide one or more of the required proofs of documentation, the household should be known to be living on the streets, parks, or other places not meant for human habitation participation as a resident of Prince William County, Manassas Park, or City of Manassas with street outreach provider within 30 days and verification can be in the following forms:
    - Verification letter by street outreach provider
    - Email exchange letter
    - Phone call follow-up by documentation

Inability to meet residency standards: if they can't establish residency any other way (where homeless certification documentation by providers is located): 30 hypothermia shelter stays (can be non-

consecutive) in a 90-day period that hypo season if cannot establish residency any other way. First piece that already exists with homeless certification takes priority over hypo shelter stays.

Non-residents of the Prince William Area on a case-by-case basis who do not want to return to their jurisdiction of origin with a ***life-threatening illness*** will have the opportunity for their case to be heard by the shelter providers and other organizations that may be involved.

Referral Process to Emergency Shelters

CES will perform the following tasks:

1. The CES Human Services Specialist will complete intake screening will all households requesting access to emergency shelter.
2. If the household cannot be diverted, the Human Services Specialist will check for shelter bed availability and if bed(s) are available, the household will be referred to an emergency shelter provider.
3. The Human Services Specialist will make a referral via the HMIS System and will also talk with the emergency shelter providers to provide any additional information (e.g., request for bottom bunk, pregnant, etc.)

The Shelter Provider will perform the following tasks:

1. The emergency shelter providers will accept the referral in HMIS and contact the household to schedule an arrival time to check into the shelter.
2. The emergency shelter providers will also schedule a time to conduct the intake assessment, completing all the intake paperwork.
3. At that time of the intake, the shelter provider will make copies of the documentation that verifies the household is a Prince William Area resident. These documents will be attached to the HMIS electronic file for the head of household.
4. In the event the household cannot provide documentation upon entry to the shelter, the household has seven (7) calendar days from entry to provide proof of residency to the case manager. Applying for benefits during the shelter stay does not count towards residency.

In the event the household cannot provide documentation by day seven (7), the following steps will be taken:

1. The case manager will determine if the household is connected to services in another jurisdiction. If the case manager cannot determine, the Program Manager of the shelter program will work with the CES Supervisor to determine if the household is receiving services from another jurisdiction. Once it is determined the household is connected to another jurisdiction or proof cannot be provided, the case manager will work with the CES to coordinate a transition back to the household's locality of origin.
2. The CES Supervisor will contact the jurisdiction of origin to coordinate a specific date to return to that jurisdiction. CES will provide transportation if necessary.
3. The CES Supervisor will inform the Program Manager of the coordinated date of return.

Procedures

CES will complete the initial assessment for all shelter providers and conduct the sex-offender registry check for all households before they are referred to family shelter providers. All shelter providers operate

under a low barrier policy which means no household will be excluded from shelter due to substance abuse history, criminal history, or previous history with any shelter provider. Shelter providers do not conduct any additional background checks for shelter admission. Additionally, CES and emergency shelter providers will do their best to ensure that no member of a household is separated from their family.

Once a referral has been made, the shelter provider will contact the household to discuss the specific shelter policy and schedule an intake time. Once a household is admitted to an emergency shelter, that provider will:

- Welcome the household to the shelter.
- Discuss with the household, when appropriate, to think of ways to solve their homelessness (review resources, family, friends, etc.).
- Complete the Shelter Intake Form, verify household identity, and if necessary, assist the household with securing a state issued ID.
- Complete the VI-SPDAT (Vulnerability Index Service Prioritization Decision Assessment Tool) with the household by day eight of their shelter stay, if the household was unable to solve their homelessness.
- Develop a Housing Services Plan to include making a referral to RRH or PSH based upon the review of the VI-SPDAT or the SPDAT.

Screening/ Assessment

Households eligible for shelter will be screened and identified by the Human Services Specialist.

Documentation

Although Photo ID is not required for shelter admission, all households must be willing to quickly work towards obtaining identifying information for all members of the household. Shelter providers will work closely to assist households with obtaining their IDs.

Adding Additional Adult Household Members

For individuals wishing to join a household currently in shelter must meet the criteria for emergency shelter. The shelter providers will perform the following task:

1. The shelter provider will hold an internal case conference with the program manager, case manager and all adults' household members to discuss shelter expectations and how they will contribute to the household housing plan.
2. A sex offender registry check is to be completed on all adults (18 years old and older) entering a shelter. To do this, go to the link below and search for the individual by entering the first and last name. **Please remember we are low barrier – therefore we only search for sex offenders. ** Link: https://www.nsopw.gov/. The shelter provider will be responsible to adding this information in HMIS.
3. If a record is found, inform the individual that they cannot enter a shelter and they will have to find other alternative arrangements. If during the hypothermia season during days hypothermia is in place, please register the client for hypothermia services.
4. The shelter provider will update the shelter intake form, VI-SPDAT, and Housing Services Plan to include the additional adult household member within seven business days. If the additional household member is a child, the shelter provider will update the shelter intake form.

5. The shelter provider will be responsible for adding the new household member in HMIS.

Adding Additional Minor child

1. The shelter provider will hold an internal case conference with the program manager, case manager, and/or the head of household or the identified care giver to discuss next steps.
2. The shelter provider will update the shelter intake form within seven business days.
3. The shelter provider will be responsible for adding the new household member in HMIS.

Referrals

All referrals for emergency shelter (except hypothermia) will originate from CES via HMIS. Shelter providers must respond to referrals as soon as possible and complete the outcomes sections of the referral via HMIS. If referrals are denied, shelter providers must provide an explanation in the comments section.

Please see the Referrals section on page 15 under Section II: Coordinated Entry for information on after-hours procedures for emergency shelters.

Domestic Violence

In the Prince William Area, ACTS is the comprehensive access point for these services (as well as survivor and family counseling services) and callers currently fleeing domestic violence will be immediately transferred to the domestic violence hotline for assessment and placement. A warm hand off with take place between CES and the Domestic Violence Hotline. All other cases will follow the current emergency shelter process. Once in shelter, households will be referred to ACTS domestic violence supportive services, if interested. ACTS Domestic Violence 24/7 Hotline number is **703-221-4951**. https://www.actspwc.org/get-help/domestic-violence

- If it is determined that the caller needs to be placed in at the Safe House by the ACTS Domestic Violence Hotline, then ACTS Domestic Violence Hotline will arrange transportation for the caller. If space is not immediately available at the Safe House, ACTS Domestic Violence Hotline staff will attempt to place the caller at an alternate location, if no other options are available caller with be placed in a motel.
- While at the motel the domestic violence survivor will receive case management service through ACTS domestic violence supportive services.
- Domestic violence survivor may be eligible for Rapid Rehousing. The case manager will assess the household for eligibility and make the referral to CES following the normal RRH procedure. The RRH case manager completing the application will be responsible for putting the client into HMIS.

The 24/7 Crisis Line Hotline 703-368-4141 is available for those callers in crisis or having thought of suicide.

Other resources for those in crisis, domestic violence or sexual assault: The Virginia Statewide Hot Line 800-838-VADV (8238) or the Virginia Sexual and Domestic Violence Action Alliance at http://www.vsdvalliance.org/ National Domestic Violence Hotline at 1-800-799-7233. For persons with hearing impairments, the national hotline can be accessed by calling 1-800-787-3224 (TTY) (domestic violence).

Termination/Discharge

Upon entry into the shelter program, households must receive written notification of the provider's grievance policy. The grievance policies must provide specific procedures to be followed for any disputed shelter decision impacting the household's shelter stay. Behaviors that present significant health and safety risks will not be tolerated at any shelter. The agency may terminate a program participant who violates program requirements only after written notice of corrective action has been given to the household and a CES case conference has been convened.

If a termination is based on an immediate health and safety risk, the program participant will be terminated but provided the grievance policy for that provider specifically outlining the appeals process.

*Involuntary discharge guidelines can be found in the appendix section of this document.
Please note: Households that are involuntarily discharged from one Prince William Area shelter will not be prohibited from gaining access to another Prince William Area shelter.

Stay Away Policy

- All clients that exit shelter to anywhere other than housing, must wait **30 days (from shelter exit)** before being eligible for any PWA shelter re-entry; with the exception of those medically vulnerable as assessed by CES. Clients can still utilize PWA DIC, hypothermia and outreach services during this time.
- Any clients discharged for behavior issues including violence (threats, weapons, physical violence) need a Community Case Conference and behavior contract in place before entering any PWA shelter again.

Shelter Suspensions and Bans

The purpose of this policy is to ensure the health and safety of all individuals that enter the shelter environment. This would include clients, visitors, partners, and volunteers. The PWA Continuum of Care operates as a low-barrier shelter. Therefore, we created several different levels of corrective actions to include temporary suspensions, shelter specific bans, and PWA system wide bans. Our goal is to work with clients to help them achieve housing but have a system in place when their behavior needs to be addressed. In circumstances of shelter specific and system wide bans the shelter ban committee will meet to discuss the incident. The shelter ban committee is comprised of the program manager from each shelter and homeless service staff.
The PWA Continuum of Care goal is adhere to the philosophy of a low-barrier shelter and believe there are some behaviors that **should not be considered an automatic suspension or ban**. These types of behavior would include but are not limited to:

a. Missing curfew
b. Language that is deemed inappropriate or disrespectful toward staff, clients, volunteers, or anyone within the shelter environment. Inappropriate and/or disrespectful language that does not include a serious threat to the safety of individuals within the shelter environment.
c. Consumption of alcohol and/or illegal drugs on the property; if the client is willing to allow the shelter staff to dispose of the alcohol and/or illegal drugs.
d. Refusal to participate in shelter services or completing housing stabilization goals.

The shelter providers will follow the steps below for the above prolonged behaviors by completing the following:

- Complete an internal case conference within 48 hours from the last behavior.
- Upload behavioral contract in HMIS in the client profile tab under file attachments.
- Complete a case note in HMIS in the client profile tab under case note section.

Temporary Suspensions will be utilized to provide an intervention to give the client(s) an opportunity to course correct their behavior at the discretion of the shelter provider. A temporary suspension should not exceed seven days.
The shelter provider can use discretion for those individuals who are medically and/or mental health fragile where temporary suspending them would be detrimental to their health and well-being. The shelter provider may use other forms of corrective actions to include, behavioral contracts and/or warning letters to address the behavior. The shelter provider would work with the client to secure temporary arrangements during the suspension. The program manager has the discretion for the number of days a client(s) should receive a temporary suspension.
The shelter provider will follow the steps below within 24 hours of the incident that results in a suspension:

- Shelter staff will complete the incident form and the shelter manager will upload the shelter incident form under file attachment in the client profile tab in HMIS.
- Shelter staff in conjunction with the shelter manager will discuss the client behavior and length of suspension. Suspensions can only be for a maximum of 7 days, so that their homeless stay is not interrupted. During suspension, clients are exited from the program in HMIS but their bed is held for them to return to.
- Upon leaving the shelter for the suspension, the client should receive a written letter on letterhead providing the reason and duration for the suspension, return date, and next steps when the client returns to the shelter program.
- Shelter Manager will add in HMIS the incident in the client profile tab under incidents and upload the written suspension under file attachments.
- Upon return to the shelter the client will have an internal case conference to discuss shelter expectations and complete a behavioral contract.
- Shelter Manager will upload behavioral contract in HMIS in the client profile tab under file attachments.
- Complete a case note in HMIS under the client profile tab, regarding the incident and suspension end date.

Shelter Specific Bans is a more serious offense where a client has presented behavior that threatens the safety and health of the shelter environment. A shelter specific ban means the client will be barred from the specific shelter for a period up to a year. These types of behavior would include but not limited to:

a. Severe behaviors in front of minor children to include exposure of body parts, physically hurting or threatening a child, bullying, and other behaviors.
b. Physical or verbal behavior that cannot be de-escalated that involves police intervention. Please note that some police departments will impose an automatic one-year no trespass that is beyond our control. Therefore, we are unable to conduct an external case conference.

c. Possessing drugs on the property with the intent to distribute or sell the drugs on the property or to other program clients.

The shelter provider will follow the steps below within 24 hours of the incident that result in a ban:

- Shelter staff will complete the incident form and the shelter manager will upload the shelter incident form under file attachment in the client profile tab in HMIS.
- Shelter staff will immediately inform the program manager to request an emergency external community case conference.
- Department of Social Services, Homeless Services Division will schedule the emergency external community case conference with the shelter ban committee to discuss the incident, review all uploaded documents, and have a consensus on the length of the shelter specific ban. Please note: if the incident is involving a minor child the client will not be permitted to another family shelter program until the completion of the ban.
- The referring shelter program manager will complete a letter on letterhead providing the reason and duration for the shelter specific ban, and next steps when the client could return to the shelter program.
- Shelter Manager will add in HMIS the incident in the client profile tab under incidents and upload the written shelter specific ban under file attachments.
- Complete a case note in HMIS under the client profile tab.
- In the event a No Trespass Notice is given; a copy should be uploaded into HMIS in the client profile tab under file attachments.
- Shelter Manager will complete a behavior contract and upload it into HMIS for next time client has an external community case conference and is seeking shelter re-reentry into any PWA shelter.
- When the client comes back through coordinated entry system, an **external community case conference** will be requested to discuss shelter expectations and complete a behavioral contract for entry into a different shelter program.

PWA System Wide Ban is the highest level of bans which means the client's behavior has severely threatened the health and safety of the shelter environment. The client(s) would not have the ability to access services for any of the Prince William Area Emergency Shelters for a period up to indefinite. These types of behavior would include but not limited to:

a. Possession of a firearm on shelter property.
b. Physical violence of harm to anyone on shelter property.
c. Bomb threat.

The shelter provider will follow the steps below within 24 hours of the incident *that result in a PWA system wide ban:*

- Shelter staff will complete the incident form, and the shelter manager will upload the shelter incident form under file attachment in the client profile tab in HMIS.
- Shelter staff will immediately inform the program manager to request an emergency external community case conference.
- The Department of Social Services, Homeless Services Division will schedule the emergency external community case conference with the shelter ban committee to discuss the incident,

review all uploaded documents, and have a consensus on the length of the PWA System Wide Ban.

- The referring shelter program manager will complete a letter on letterhead providing the reason and duration for the PWA System Wide Ban, and next steps when the client could return to the PWA Homeless System.
- The Shelter Manager will add in HMIS the incident in the client profile tab under incidents and upload the written PWA System Wide Ban under file attachments.
- Complete a case note in HMIS under the client profile tab.
- In the event a No Trespass Notice is given; a copy should be uploaded into HMIS in the client profile tab under file attachments.
- Shelter Manager will complete a behavior contract and upload it into HMIS for next time client has an external community case conference and is seeking shelter re-reentry into any PWA shelter.
- When the client comes back through coordinated entry system when PWA System Wide Ban has ended, an external community case conference will be requested to discuss shelter expectations and complete a behavioral contract for entry into a different shelter program.

Section VI – Housing Location Services

All case managers, street, and CoC providers will be responsible for performing housing location duties.

Section VII – Rapid Re-Housing

Overview and Purposes

Based on national research and best practices, the PWA has committed to investing the CoC funding provided through the HUD CoC Grant, Virginia Homeless Solutions Program (VHSP) and Virginia Housing Trust Fund funds in rapid re- housing assistance for homeless households, and/or any local, state, federal, or private funds. All Partnering Agencies or Providers must follow all regulations and guidelines as stipulated with each of the funding sources identified.

In addition, to the funding sources listed above, Prince William County Office of Housing & Community Development (OHCD) administers the Emergency Solutions Grant (ESG) that is funded through an allocation from the U.S. Department of Housing and Urban Development (HUD). OHCD has allocated a portion of the federal grant award for Rapid Re-Housing activities. Sub- recipients that are awarded Rapid Re-Housing funds must follow all regulations and guidelines as stated within the Prince William County ESG Grant Agreements. In addition, The ESG Grant is subject to the terms, guidelines and regulations set forth in the Prince William County Emergency Solutions Grant Operating Manual.

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. The household has a lease in their name and is connected to mainstream self-sufficiency services in the community. Partner Agencies 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 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.

The PWA has implemented the following Best-Practice Rapid Re-Housing Strategies.

- Housing First.
- Short-term, Moderate-term, and Long-term Rental assistance.
- Flexible funding for security and utility deposits.
- Housing focused Case Management in the home to help access needed services to move to self-sufficiency, including:
    - Employment Services.
    - Budgeting.
    - Public Benefits such as childcare, SNAP, tax credits, Medicaid, and TANF.
- An organized housing search strategy including landlord mediation.

Households 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. Households are required to meet with a case manager at a minimum of once per month and actively participate with their Housing Plan.

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

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, their relatives, or employees. **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 in their name. A copy of this lease must be included in the program participant's record. The identified housing unit must meet the Habitability Standards of each funding source's requirements.

Providers 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 that could impact housing stability.

Households To Be Served

The Rapid Re-Housing program targets PWA households who are homeless. These include the following households.

- Individuals and families are reserved for persons who meet the HUD definition of literally homeless. Those that who lack a fixed, regular, and adequate nighttime residence including those residing in a shelter or a place not meant for human habitation.

- Veterans- who will be served through veteran specific RRH providers**.**

Eligibility Populations

Table 7.1– 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 (less than 90 days). 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 (VI-SPDAT) must be completed at program entry with an immediate focus on housing stabilization.
Category 4	**Fleeing Domestic Violence/ Expanded definition of Category 4 Homelessness (DV Survivors)**	Individuals or households fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, life-threatening situations related to violence and who also lack the resources or support networks to secure new housing. **VAWA 2022 Amended McKinney-Vento Definition of Homelessness Category 4** Any individual or family who • Is experiencing trauma or a lack of safety related to, or fleeing or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic, or life-threatening condition • related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety, of children are jeopardized • Has no other safe residence, and • Lacks the resources to obtain other safe permanent housing.

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

Re-certifications:

Program Re-certification requires agency certification and evidence of the following.

- Program participant household income must be 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.

Income is not required at entry for VHSP and HUD projects, however, other funding sources such as ESG may have income requirements at entry. Please review applicable funding guidelines for entry requirements. Households must be literally homeless to access Rapid Re-housing services. Re-certification occurs every 90 days for continued services from applicable funding streams.

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

Procedures

To access Rapid Re-Housing Services the procedures listed below will be followed.

- ES staff will continue to work with the household, discussing options for potential diversion from shelter.
- If the household cannot be diverted, on day eight, ES staff will complete the Vulnerability Index-Service Prioritization Decision Assessment Tool (VI-SPDAT). The VI-SPDAT score will be used as a guide to determine the best housing approach for the household. If the household is determined to be an appropriate fit for RRH, the ES staff will consult with the household regarding the guidelines of RRH, being clear about what RRH is and what it is not.
- The Household will be provided with the RRH Program Agreement and Expectations document.
- If the household agrees, RRH is the next best step, the shelter case manager will upload application in HMIS.
    - **SPECIAL NOTE:** The referral will be made regardless of RRH availability. The CES will maintain a by-names list of households. Households are placed in order of critical housing need and may be admitted to any RRH program within the PWA CoC.
    - **The rapid re-housing committee convenes biweekly to discuss provider availability, assign new cases, and funding status.**
- Case manager will upload all required paperwork to the head of household's file in HMIS as described in the CoC's most recent guidance.

CES Manager will:

- Upon receipt of the referral (via email from the HMIS System), the CES Manager will review the RRH referral for completeness.
    - If the referral is not complete, the CES Manager will decline referral in HMIS.

  - A provider note will be added to the client profile stating the reason for denial. The referring organization will need to resubmit the entire referral if documentation is missing.
  - If the referral is complete, the CES Manager will accept the referral in HMIS. Acceptance of the referral does not mean acceptance to a designated RRH Provider. It signifies the referral paperwork is complete and the household has been added to the RRH by-names listing.
- Submission of rapid rehousing referral to CES does not automatically indicate placement on the by-names list or acceptance to the rapid rehousing program.
- Based upon the Prioritization Score, households will be added to the RRH by-names-list. Households will be listed by date and their Prioritization Score provided.
- Referrals will be maintained on the By-Names-List from data directly from HMIS that includes the following.
  - HH's first and last name, HMIS #, Referral date, VI-SPDAT Score, Prioritization Score.
  - HH's will be listed in order of Prioritization and referral date if the Prioritization Score is the same.
  - The By- Names- List will be shared via email with RRH providers.

- Assignments will be made by the CES Manager when an opening is available during the biweekly RRH meeting (**2nd and 4th Tuesday of the month**). The RRH case manager, the funding source and date household was accepted into RRH will be listed on the By-Names-List. On the **3rd Tuesday** of the month, the RRH Provider will participate in the RRH Admin Meeting to discuss accepted RRH slots, active cases, and case projections to support the inflow and outflow of participants in our CES.
  - The RRH provider will contact the household's case manager to schedule the initial meeting.
- There will be one (1) BNL for RRH, which DSS/HSD (CES Manager) will update at least once weekly.
  - A separate BNL will be maintained for PSH.
- **RRH VHSP** providers can directly take persons' from their respective emergency shelters to move HHs into VHSP RRH.
  - They will remove HHs based on current prioritization (High, Medium, Low).
  - VHSP Providers are permitted to dedicate 20% of their budget towards slots to assist households who are move-in ready.
  - Budgets and slot amounts must be submitted to CoC Lead and CES Manager for review.
  - Slots from their respective agency must be submitted to pwacocrrh@pwcgov.org.
  - CES manager will track and monitor slots with provider during RRH Admin as needed.
  - Providers are expected to follow VHSP guidelines.
- The RRH Partnering Agency will keep the CES Manager informed should the case manager/household neglect to follow through or meet when scheduled.
  - For Community referrals: RRH partners will make three attempts within a seven-day period to contact a household for services once an initial referral is received, if the household does not respond, the RRH provider will document the attempts in HMIS under provider notes and notify the CES Staff of such attempts. The RRH provider will continue to attempt at contact for up to 90 days.

- If there is no contact with a community referral after 90 days, the household will be moved to the removed list.
- If the household is interested in RRH in the future, they will need to initiate the RRH referral process again.

Partnering Agencies

There are three partnering agencies that offer various levels of rapid re-housing services to households through various funding streams.

- Action In Community Through Services (ACTS PWC)
- Northern Viriginia Family Services (NVFS)
- Prince William County DSS-Homeless Services (HSD)

Note: All programs will accept eligible households 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 as described in Table 6.1. Households that have been screened and determined to be eligible to receive Rapid Re-Housing, will be informed about the level of assistance that will be provided. Reference Table 7.2 below regarding the varying levels of services to be provided.

Table 7.2 - Type of Rapid Re-Housing Assistance

Level 1	**Short-Term Rental Assistance**	Household will need minimal assistance to obtain and retain housing, including: • 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, including: • 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 reduced 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. The rent assistance can be stepped down (gradually decreasing 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. Including: • 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 reduced 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** The program is designed to assist households that appear to need intensive case management services in the home coupled with financial assistance. The barriers (e.g. poor money management, low-income wages) are extensive and may have more than one 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. The rent assistance can be stepped down (gradually decreasing 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, including: • 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 reduced 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 meeting the 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 (e.g., poor money management, low-income wages) are extensive and may have more than one 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. The rent assistance can be step down (gradually decreasing 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, including: • 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 reduced to bi-weekly or monthly as most of the 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 meeting the housing goals. **Length of time: 18-24 months**

Documentation

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

- Proof of household composition.
- Proof of Homelessness.
- Proof of assets, if applicable (401K, recent bank statements, etc.).

Prioritization

PWA Rapid Re-housing providers have committed to serving a specified percentage of households based on need. The following list outlines the percentage of households each provider will service based on need.

- 35 % of Households with higher need- households with a VI-SPDAT score of 7 or higher
- 45% of household with medium need- households with a VI-SPDAT score of 5-6
- 20% of households with lower need- households with a VI-SPDAT score of 4 or below

PWA has chosen to use the VI-SPDAT score in combination with the priority population ranking score to determine a priority listing for households to receive RRH services. The following list outlines the total possible VI-SPDAT score:

- VI-SPDAT (Single)
  - 0-4 –low
  - 5-9 medium
  - 10-17 high

- VI-SPDAT (Family)
  - 0-3 low
  - 4-8 medium
  - 9-above high

The PWA has established the following priority populations and ranking score for all Rapid Re-housing programs. Households that fall into the following categories rank highest in priority for this housing strategy.

- Families with children with greatest service need (4pts.).
- Aging households over 62 with medical need or disability (3 pts.).
- Youth- aged 18-24 (2 pts.).
- Households without income (1 pt.).
- Currently Fleeing Domestic Violence (additional 2 pts.)
- Veterans (regardless of discharge status) will be prioritized with but not limited to veteran specific providers.

The following list outlines the total combined VI-SPDAT and priority population ranking score which will determine placement and household need on the rapid rehousing by-names list.

- 1-7- low need
- 8-14 -medium need
- 15-above- high need

The strategy shall also 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 households 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 and utilities.

The PWA Rapid Re-Housing programs have a level of flexibility to provide households with rental assistance that includes:

- **Income-based Subsidy (Progressive Engagement)**: Under an income-based model, a household pays a specific percentage of its income towards rent and utilities (e.g., 30 percent, 40 percent, or 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 a household 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 their long-term subsidies.

When partnering agencies are using 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.

Referrals

Most referrals for Rapid Re-housing are initiated by the Emergency Shelter and Outreach programs. Households shall not be housed with RRH funds prior to this meeting.

Termination

Any individual seeking and/or receiving rapid-rehousing assistance must be provided written notification of the agency's grievance policy. Grievance policies must include 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 CES case conference has been 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 a review of the decision in which the program participant is given the opportunity to present written or oral objections to a person other than the person (or a subordinate of that person) who made or approved the termination decision.
(3) Request and attend a case conference if issues are not resolved.
(4) Provide prompt written notice of the final decision to the program participant. The aforementioned documentation must also be submitted to the CES Manger: PWACoCRRH@pwcgov.org .

Outcome Measures

The PWA CoC has adopted the National Alliance to End Homelessness (NAEH)/ Virginia Department of Housing and Community Development (DHCD) RRH Benchmarks and Standards. The standards are based on what are currently considered promising practices by the National Alliance to End Homelessness, the U.S. Department of Veteran Affairs (VA), the U.S. Department of Housing and Urban Development (HUD), U.S. Interagency Council on Homelessness (USICH), and other federal technical assistance providers, and nationally recognized, high-performing RRH providers. These program standards will be updated as RRH practices continue to evolve.

Performance Benchmarks

Ultimately, the effectiveness of an RRH program is determined based on a program's ability to accomplish the model's three primary goals. They are:

(1) Reduce the length of time program participants spend homeless.
(2) Exit households to permanent housing.
(3) Limit returns to homelessness within a year of program exit.

Processing referrals with HMIS:

Homeless Services is responsible for coordinating rapid rehousing and permanent supportive housing by ensuring that referral applications have been completed and all documentation required has been attached in HMIS. HSD is not responsible for the accuracy of the application. The receiving provider will be responsible for accuracy of all documentation and ensuring the referral meets program eligibility requirements. Additionally, Homeless Services is responsible for ensuring that the next scheduled household is taken off the By Names List (BNL) based on the prioritization assessment tool.

Section VIII- Community Partnership Funding One Time Assistance

Overview and Purpose

The CPF's mission is to provide financial incentives to landlords and facilitate housing opportunities for individuals experiencing homelessness. Eligible clients include those who are literally homeless (residing in shelters or on the streets), connected to the Prince William Area Continuum of Care, and capable of sustaining the housing unit. This program allows low vulnerable participants who are experiencing homelessness to access permanent housing quickly and efficiently. These funds provide one-time assistance and are not considered Rapid Rehousing. Assistance must cover the full first month's rent indicated in the client's lease upfront at move-in (non-prorated).

The DSS Homeless Services Division (HSD) will oversee the monitoring and tracking of all Landlord (LL) Incentives to ensure accuracy, accountability, and equitable distribution. CPF Providers may receive new LL Incentives on a rolling basis. Providers must also CC DSS Homeless Services at homelessservices@pwcgov.org on all related communications related to incentive only referrals. Each provider is responsible for maintaining and regularly updating their LL Incentive Tracking Spreadsheet, which will be shared among providers to prevent duplication. All incentive entries must include complete landlord information, including both the LLC name (if applicable) and the landlord's first and

last name. Providers and applicants must comply with the procedures outlined in the Landlord Incentive Tracking Procedure and the One-Time Assistance Community Partnership Funds policy listed below.

Referral Process

- Residents must be literal homeless.
- Referring agencies are responsible for 30 days of case management to prevent recidivism.
- Referrals will include housing sustainability: proof of income, bank statement, length of current employment, and history of receiving one time assistance.
- Funding agencies will notify providers of the vacancy and include PWACoCRRH@pwcgov.org.
- The referring case worker will email the CPF agency the CPF one pager application.
    - Attachments will include W-9, lease, proof of ownership, ACH and LL contact.
- Referrals will be emailed directly to
    - ACTS (CPFunding@actspwc.org)
    - NVFS (CPFunding@nvfs.org)
    - CC' CES Manager (PWACoCRRH@pwcgov.org) on all emails.
    - Providers will respond within two business days.
- **HMIS Data Entry**
    - The referring provider will complete the following in HMIS for approved households at the point of project exit on the head of household's record:
        - Service Transaction for One-Time Assistance
        - Service Transaction for Case Management
    - The HMIS exit destination for households receiving one-time assistance is "Rental by client, no ongoing housing subsidy".

Section IX – Permanent Supportive Housing

Overview & Purpose

Based on national research, the PWA has committed to using some of its funds to operate the best practice model of the Permanent Supportive Housing Programs (PSH) for persons identified as chronically homeless. PSH is a strategy that permanently houses individuals and families as quickly as possible. All of the CoC's PSH Programs use a Housing First model that means that households are moved into housing despite barriers to accessing housing (e.g., criminal history, poor credit, etc.) and no requirements are placed on the household to access the program.

The PSH program is designed to provide a rental subsidy in conjunction with the household paying 30% of their income toward rent. Each household will have a program agreement, or the program will use a corporate lease with program participants.

The program also provides housing-focused case management services that assist the household in maintaining 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 as well**.

Typically, households have demonstrated a clear need for supportive services and without these supportive services, once placed they will be unable to maintain their housing. Supportive services are expected to remain engaged with the households for the entire time the household is enrolled in the program. In some circumstances, households may be required to enlist the services of a representative payee that will be responsible for ensuring that the household's monthly rent and other expenditures are paid. PSH programs also connect households to mainstream benefits and services in the community. 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.

The PWA has implemented the following best practice PSH Strategies:

- Housing Location Services for persons with high barriers to securing housing.
- Long-term Rental assistance.
- 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 childcare, SNAP, tax credits, Medicaid TANF, etc.

Households to be served

Notice CPD-14-12 suggests four levels of priority for CoC Program-funded PSH that is either dedicated or prioritized.

1. First priority is for those who have severe service needs and who were chronically homeless for at least 12 months, either continuously or on at least four separate occasions that add up to 12 months over the last three years.
2. Second priority is for those who do not have severe service needs, but who were chronically homeless for the above time periods.
3. Third priority is for those who have severe service needs and who were chronically homeless on at least four separate occasions that add up to less than 12 months over the last three years.
4. Fourth priority is for those who do not have severe service needs, but who were chronically homeless for at least 12 months, either continuously or on at least four separate occasions that add up to less than 12 months over the last three years.

The order of priority for CoC Program-funded PSH that is not otherwise dedicated or prioritized is as follows.

1. First priority is for individuals or families with a member with a disability and severe service needs, and who were homeless for any length of time, including those who are exiting an institution where they lived for 90 days or less but who were homeless before entering the institution.
2. Second priority is for individuals or families with a member with a disability who were homeless either continuously for six months or on at least three separate occasions that add up to six months over the last three years. This includes those exiting an institution where they lived for 90 days or less, but who were homeless either continuously for six months or on at least three separate occasions that add up to six months over the last three years before entering the institution.

3. Third priority is for individuals or families with a member with a disability who are homeless, including those exiting an institution where they lived for 90 days or less, but who were homeless before entering the institution.
4. Fourth priority is for individuals and families with a member with a disability who are:
    a. Coming from transitional housing, but who were homeless before living in transitional housing.
    b. Fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking who are living in transitional housing, even if they were not homeless before entering transitional housing.

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

Re-certifications

Programs should continuously evaluate a household's needs 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.

Admissions Committee

The PWA 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.

- 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.
- Review CoC PSH referrals to determine which households will be placed in PSH.
- 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 member from each the organizations/programs that provide permanent supportive housing programs within the PWA CoC:

The AC uses the following weighted measure criteria to impartially determine the household that will receive the next open slot for PSH programs within the CoC. The weighted measure will be based on the VI-SPDAT score and the following criteria.

- Chronically Homeless (based upon HUD's definition).
- History of service in Armed Services (Army, Navy, Marines, Air Force, Coast Guard).
- Length of chronic homelessness (Households that have been homeless the longest).
- Physical Health (Severity).
- Mental Health (Severity).

Other considerations can include:

- Heavy user of system services (hospital, jail, mental health hospitalizations, etc.).

Providers/Partnering Agency

There are several providers in PWA responsible for delivering PSH services to eligible households.

Screening/Assessment

To be eligible for PSH programs a household must meet the HUD definition of chronically homeless described in Table 7.1. Households that have been screened and determined to be eligible to receive PSH must follow these steps.

- Make a referral via the HMIS system. The referrals shall be routed to CES and must include all required documentation (e.g., PSH admission committee questionnaire, chronically homeless documentation form, disability, etc.)
- The CES Team will review the referral within 10 business days for completeness and chronically homeless requirements.
- The CES team will establish a time for the case to be presented before the PSH Admissions Committee.
- The PSH Admission Committee meets monthly to discuss, accept, or deny cases and rank the household according to the CoC Prioritization Criteria.
- If accepted, the referral source will be informed via email of acceptance to the PSH Pool.
- Case management services of a specific PSH program 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 HMIS system.

Documentation

To be eligible for PSH, households/providers must provide all required documentation located in HMIS under client number one.

Terms of Assistance

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

- Households should be identified as **chronically homeless** prior to entering the program. If the head of household is not chronically homeless the PSH committee may approve the household based on the PSH prioritization standard.
- Additionally, the household demonstrates a need for supportive services that can assist the household, once placed, in maintaining their housing.

- 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 using 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.

PSH Move-on Strategy

This move-on strategy is designed to support individuals with disabilities who have achieved stability in PSH and are ready for more independent living. The goal is to transition them into appropriate housing while ensuring continued access to necessary support, creating openings for those with greater needs. The assessment should be kept in the client file.

Assessment and Readiness Evaluation

- Conduct comprehensive assessments to evaluate the client's ability, including medical needs, financial readiness, and social support to live independently with less or without structured case management services.
- Develop individualized move-on readiness criteria, including financial sustainability, mental health stability, and social support systems to include home health aides or other in-home supports.
- Engage clients in discussion about their long-term housing goals. To ensure a person-centered approach to housing transitions.

Housing Navigation & Support

- Identify and secure affordable housing options, such as subsidized apartments, voucher and waiver programs.
- Assist clients in applying for housing subsidies and support programs. During open enrollment clients will apply for a waitlisted program and received technical assistance if needed. This will ensure an extra layer of support for individuals for maybe independent while waiting.
- Assist client with screening by the health department for long-term care, CCC+ and DD waivers

Skills Development & Resource Connection

- Provide independent living skills training, such as budgeting, medication management, and self-advocacy.
- Connect clients to employment and vocational rehabilitation programs.

- Ensure continued access to disability benefits (SSI/SDDI), and health services. All clients will apply for financial or medical benefits to include Medicare and Medicaid and seniors 65+ for Medicare Benefit Card for funding up to $380.00 that can be used for transportation services, utilities, and food.

Transition Support & Post-Move Stability

- Develop a transition plan with all the support services needed to sustain housing.
- Offer moving resources (financial, deposits, and/or furniture referrals).
- Provide 30 days of move-in services to monitor the transition. If funding and capacity will allow the transition.

Termination

Any households participating in a CoC PSH Program must be provided written notification of the agency's grievance policy. Grievance policies must describe specific procedures to be followed for any disputed PSH 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 a 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 a review of the decision, in which the program participant is given the opportunity to present written or oral objections to an organizational representative other than the person (or a subordinate of that person) who made or approved the termination decision.
(3) Provide prompt written notice of the final decision to the program participant. The aforementioned documentation must also be submitted to DSS/Homeless Services/CES.

Processing referrals with HMIS:

Homeless Services is responsible for coordinating rapid rehousing and permanent supportive housing by ensuring that referral applications have been completed and all documentation required has been attached in HMIS. HSD is not responsible for the accuracy of the application. The receiving provider will be responsible for accuracy of all documentation and ensuring the referral meets program eligibility requirements. Additionally, Homeless Services is responsible for ensuring that the next scheduled household is taken off the By Names List (BNL) based on the prioritization assessment tool.

Outcome Measures

Partnering agencies should meet the outcome measures established in the CoC Report Card.

Emergency Transfer Plan VAWA

The complete PWA CoC Emergency Transfer Plan with attachments is posted on the Prince William County Continuum of Care website and the CoC Platform Civic Roundtable.

Relationship to Other Policies

Virginia Civil Code

Virginia Civil Code (§ 55.1-1236) allows any tenant who is a victim of domestic violence, sexual abuse or other criminal sexual assault may terminate such tenant's obligations under a rental agreement. This law empowers survivors to leave abusive situations while avoiding the usual penalties associated with breaking a lease. Personnel involved in implementing emergency transfer for tenants for HUD housing assistance will comply with this code.

Case managers and other HPs will assist HUD- assisted households in early termination of a lease when necessary, by (1) advising tenants of their rights and offering written information and (2) informing landlords of this Civil Code.

Safety and Security of Tenants

Pending processing of the transfer and the actual transfer, if it is approved and occurs, the tenant is urged to take all reasonable precautions to be safe.

Tenants who are or have been victims of domestic violence are encouraged to contact the National Domestic Violence Hotline at 1-800-799-7233, for assistance in creating a safety plan. For persons with hearing impairments, that hotline can be accessed by calling 1-800-787-3224 (TTY).

Tenants who have been victims of sexual assault may call the Rape, Abuse & Incest National Network's National Sexual Assault Hotline at 800-656-HOPE, or visit the online hotline at https://ohl.rainn.org/online/.

Tenants who are or have been victims of stalking seeking help may visit the National Center for Victims of Crime's Stalking Resource Center at https://www.victimsofcrime.org/our-programs/stalking-resource-center.

ACTS Domestic Violence Hotline 24/7 support (703) 221-4951. Documents can be **i**n HMIS under client 1 (Yogi Bear).

Veterans

The CoC is committed to ending Veteran homelessness. If/when a veteran is identified at CES for Prevention, Diversion, Rapid Rehousing, or Permanent Supportive Housing, the worker must update the HMIS record. This provides the basis for a robust service response that includes coordination with Veterans Administration (VA) for HUD-VASH and SSVF and prioritizing non-VA eligible Veterans for CoC assistance.

Veteran Definition

Any person who has served in the United States Armed Forces, regardless of discharge status, or length of time served (this includes all Veterans, National Guard, and Reserves).

Veteran Priority Population

Households with minor children: Households actively experiencing literal homelessness where there is at least one adult Veteran (18+) and one child (under the age of 18)

- Chronically homeless households: Households actively experiencing literal homelessness where the Veteran has a diagnosable disability and recorded history of frequent homelessness (one continuous episode that has lasted one year or more; or 4 or more episodes over the past 3 years that total 12 months).
- Disabled households: Households actively experiencing literal homelessness where the Veteran has one or more disabilities as defined by US Dept. of Labor.
    - Special Disabled Veteran
    - Service-Connected Veteran
    - Non-Service-Connected Veteran
    - Individual with a Disability (ADA)
- Unsheltered households: Households where the Veteran is actively sleeping in places not meant for human habitation.
- Aging adult households (55+): Households actively experiencing literal homelessness where the Veteran is age 55 or older.

Processing referrals with HMIS:

Homeless Services is responsible for coordinating rapid rehousing and permanent supportive housing by ensuring that referral applications have been completed and all documentation required has been attached in HMIS. HSD is not responsible for the accuracy of the application. The receiving provider will be responsible for the accuracy of all documentation and ensuring the referral meets program eligibility requirements. Additionally, Homeless Services is responsible for ensuring that the next scheduled household is taken off the By Names List (BNL) based on the prioritization assessment tool.

PWA CoC Forms

All documents can be found on the CoC platform Civic Roundtable.