



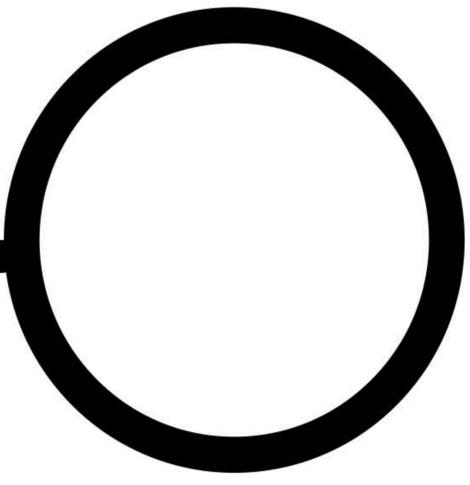
DENTON COUNTY
HOMELESSNESS
LEADERSHIP TEAM

IN PARTNERSHIP WITH

United Way of Denton County, Inc.

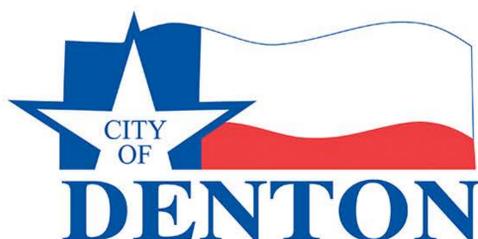
STANDARDS

OF EXCELLENCE



GUIDELINES FOR CONTINUOUS IMPROVEMENT
OF DENTON COUNTY'S
HOMELESS CRISIS RESPONSE SYSTEM

SUMMER 2018



**United Way
of Denton County, Inc.**

The **STANDARDS OF EXCELLENCE** are a set of **performance goals** and **quality standards** for outreach & engagement, emergency & temporary housing, and supportive housing programs. More importantly, they are a framework for applying principles of **coordinated** practices at both programmatic and system levels.



Concrete, consistent standards are critical to ensuring we focus our efforts and resources in the most effective ways possible. In a reality where all resources are extremely limited, we need to think smarter about our current strategies and investments in the community, and to push forward solutions that help us ensure that homelessness is **rare, brief and nonrecurring.**

STANDARDS OF EXCELLENCE

The **STANDARDS** are meant to:

- Identify opportunities for building on strengths and creating more effective programs;
- Make it easier for funders to more consistently acknowledge and reward those that are the most effective;
- Reduce the complexity of performance reports and requests for proposals;
- Push our community to set real goals towards ending homelessness, especially veteran and chronic homelessness, and improve outcomes overall.

The **STANDARDS** are **NOT** meant to:

- Take away funding - They are meant to encourage increases in resources for the programs that reduce homelessness.
- Create more work - They are based only on the most critical program requirements and outcomes that most funders already expect measured. They are also completely voluntary.
- Bring negative attention to 'low performers' - They are meant to highlight those that go above and beyond, and to create strength-building opportunities for others that wish to do the same. All of us are making critical contributions toward ensuring homelessness is **rare, brief and nonrecurring** in Denton County, and the STANDARDS are meant to help everyone do even better.

Through the STANDARDS, the Denton County Homelessness Leadership Team Housing Workgroup can work to ensure that everyone has access to the resources and tools necessary to ensure that homelessness is **rare, brief and nonrecurring** in Denton County.

STANDARDS OF EXCELLENCE

GOALS & INDICATORS

**Markers and metrics of programs
that make measurable progress**

OPERATING STANDARDS

**Hallmarks of high
quality programs**

SUGGESTED PRACTICES

**Strategies for
continuous improvement**

SYSTEM RECOMMENDATIONS

**Opportunities for
effective change**

STANDARDS OF EXCELLENCE

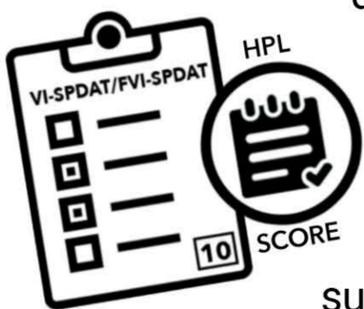
A critical aspect of our Housing Crisis Response System is a focus on the local response as a coordinated system of homeless assistance options as opposed to homeless assistance programs and funding sources that operate independently in a community. To facilitate this, the Denton County Homeless Leadership Team adopted six shared goals to establish **Goals and Indicators** that measure performance of our coordinated system. These system performance measures are:

SYSTEM PERFORMANCE MEASURES

- # Reduce the Number of Homeless
- 🕒 Reduce the Length of Homelessness
- 📈 Reduce those who are homeless for the first time
- 🔄 Reduce returns to homelessness
- 🚧 Reduce Barriers to increase access to housing
- 💰 Increased Income
- 👥 Identify vulnerable populations in need of housing

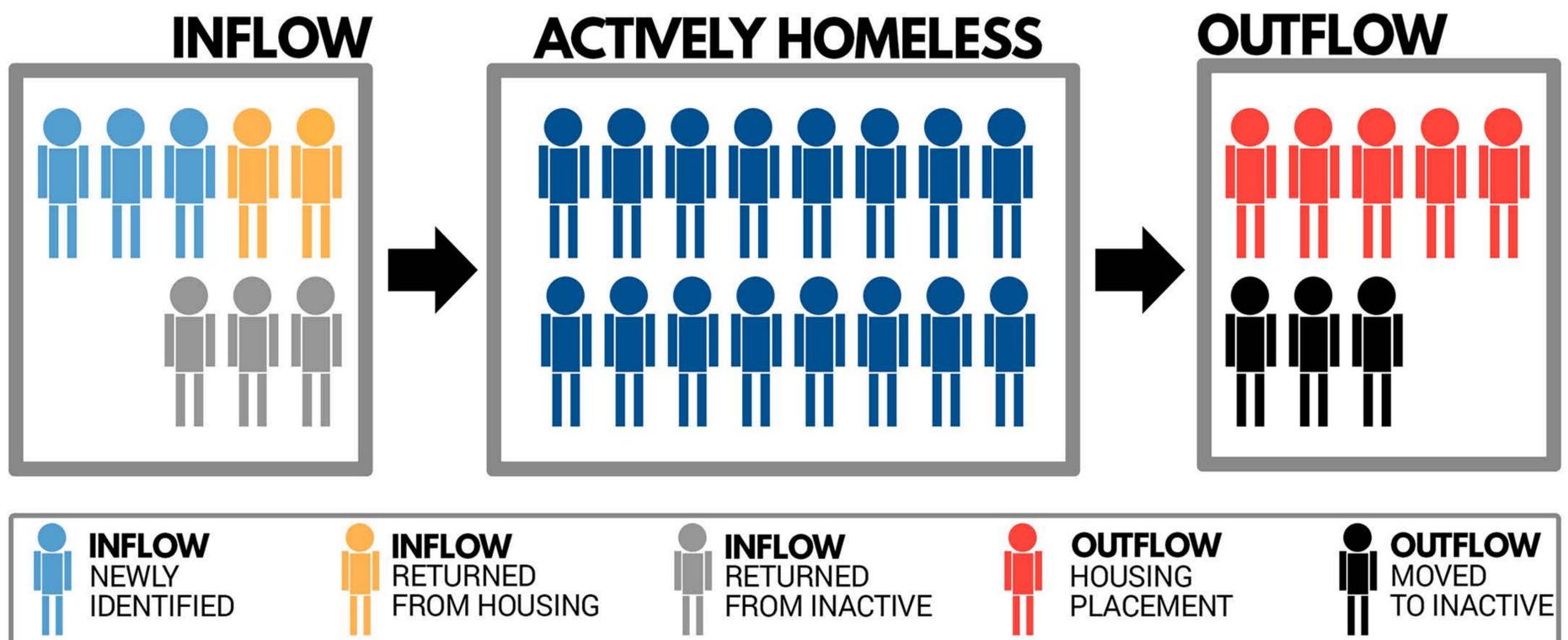
HMIS and COORDINATED ENTRY

To measure performance in these areas continuous improvements in homelessness data management and the implementation of Coordinated Entry (CE) in Denton County was required as **Operating Standard**. It is now possible to track, in real-time, data that is critical to the overall understanding of housing needs for people experiencing homelessness and the ability to identify gaps in housing CE is the system and process that ensures people who are experiencing homelessness are quickly identified, assessed, and connected to housing assistance and supportive services that promote housing stability. Data improvement included coordination of efforts to maximize the number of people contributing data into a shared database, the Homeless Management Information System (HMIS).



HOUSING PRIORITY LIST

It is **Suggested Practice** to create and sustain a by-name list that accurately reflects the number of people experiencing homelessness at any given time in a community. The CE system in HMIS now produces the Housing Priority List (HPL), an actionable, real-time dataset. The HPL is an up-to-date list of all people experiencing homelessness that includes categories such as Veteran status, chronic status, active/inactive status, homeless/housed status, and more. The HPL allow us to know every person experiencing homelessness by name and facilitate efficient decisions around how best to refer individuals experiencing homelessness to housing resources.



The data provided by these tools is used to generate **System Recommendations** in preparation for rates of homelessness, including inflow. It is also used in refining goals and indicators (or other performance management targets used in ending homelessness), and the tools including CE, HMIS and the HPL.

STANDARDS FOR OUTREACH & ENGAGEMENT



GOALS & INDICATORS

Initial Engagement

75% coverage of Denton County service area, track # of total engagements made, # of unique engagements

Assessment

90% of those engaged are CE assessed for housing using the VI-SPDAT

Housing Navigation

50% of those eligible are successfully assisted in collecting all housing documents w/in 30 days of engagement

70% placed in temporary, transitional or permanent housing

OPERATING STANDARDS

- **Effective Partnerships:** Participates in local Coordinated Entry (CE) system by working as housing navigators and assessors, using the VI-SPDAT, and preparing necessary documents for housing placement.
- **Personnel:** Send teams of 2 or more, 18 or older.
- **Qualifications:** Train on, at minimum, core values, physical & health safety (including blood borne pathogens), boundaries, ethical guidelines, triaging, mental health & substance abuse symptoms, and housing assessment.
- **Self-Care:** Policies are in place to ensure outreach staff maintain physical & mental well-being.
- **Availability:** Outreach also occurs on nights and weekends.
- **Services:** Offer referrals to services, & housing, including at minimum access to shelter beds, IDs, physical & mental health care, substance use treatment and benefits and employment assistance, based on what the client wants without prerequisites (such as sobriety, program completion, or medication- compliance).
- **Service Area:** Provider has identified a clearly-defined service area in Denton County.
- **HMIS Use:** Provider has fully implemented the program in HMIS and actively participates in it.
- **Self Determination:** Client Choice in Housing.

STANDARDS FOR OUTREACH & ENGAGEMENT

SUGGESTED PRACTICE

Approaches

- Individualized, consistent, progressive engagement.
- Motivational interviewing. Identification.
- Warm hand-offs by integrating other staff into outreach team.

Assessment

- Map locations of client interactions to establish movement patterns (e.g. using a simple grid/sector system).
- Document all interactions daily. Measure refusal rate to understand sentiments toward services offered in specific populations and geographies.

Staffing

- Employ multilingual staff.
- Ensure that all staff are culturally- competent & -sensitive.
- Employ a multi-disciplinary team or partnership (including legal supports). Ensure outreach team is certified in CPR. Train on emergency health response & secondary trauma.
- Carry cell phone & business cards; have access to van with child safety seats.
- Promote peer/alumni representation on teams.
- Test for TB annually & on occasions of exposure.
- Maintain 8-hour days to prevent burnout.

Partnerships

- Creation & maintenance of effective partnerships with other service providers, whether by choice or necessity; ones that complement each program's approaches, that will lead to transitions that most benefit clients, and that encourages continued engagement and follow-up afterwards.
- Proactive engagement with law enforcement (e.g., introduce at roll call, contact senior lead officer).
- Involve businesses in outreach efforts. Advocate for clients with law enforcement, Housing Authority, service providers, discharge sites, landlords.

SYSTEM RECOMMENDATIONS

Data

- Facilitate mobile data entry with regular trainings on data standards.
- Adjust consent protocols to allow supportive service providers to look up clients and communicate with outreach workers regarding housed clients.
- Allow partial record entry into HMIS by using alternative identifier (e.g. picture, nickname) instead of name or SSN.
- Encourage broader HMIS use across system & data sharing to allow tracking.

Housing

- Funding and resources should be utilized to support a coordinated entry system that quickly connects people to housing, is built on effective partnerships that enhance service capacity and promote housing retention and community integration.
- Identify interim housing options for those awaiting permanent housing.
- Identify and eliminate existing developer and systemic barriers to accessing permanent supportive housing using Housing First strategies.

Partnerships

- Create strategy regarding balance between outreach & housing retention functions for programs that do both.
- Create outreach ID to present for services and to law enforcement.
- Encourage tempered law enforcement tactics to prevent arrests that endanger housing placements.

STANDARDS FOR EMERGENCY/TEMPORARY HOUSING



GOALS & INDICATORS

Assessment

90% are assessed for housing through CE using the VI-SPDAT

Diversion

Those eligible are diverted from homelessness by identifying immediate alternative housing

Length of Stay

50% exit within 120 days. (exits include diversion, extended stay, or other housing)

Housing Navigation

35% exit to temporary or transitional housing destinations

40% exit to permanent housing destinations

Guest Satisfaction

70% of those who stay, would recommend the shelter to someone else in need

OPERATING STANDARDS

- **Coordination:** At least 10% of beds provided are prioritized for those who have been matched to housing through CE and are awaiting placement.
- **Assessment:** All guests are screened for diversion or CE intake within 24 hours.
- **Low-Barrier Eligibility:** Guests are not required to: be clean & sober, complete treatment, be employed (or at a prescribed income level), or be med-compliant to enter shelter.
- **Staffing:** Agency maintains a ratio of no less than 1 case manager/housing specialist to 30 guests participate in case management.
- **Alumni Involvement:** Avenues exist for alumni & peer support in the delivery of supportive services for current participants.
- **Income:** All guests are assisted in receiving all eligible benefits (at minimum SNAP, SSI, SSDI, VA) &/or achieving earned income.
- **Grievances:** Every guest is given protocols for expressing grievances during shelter stay.
- **Compliance:** Shelter is ADA-compliant
- **Family Separation:** Resources or referrals are in place that will shelter families without separation.
- **Documentation of Shelter Stay:** Shelter will maintain documentation of every guest's shelter stay in order to provide homeless certification when needed through a designated point of contact.
- **Length of Stay:** Individualized Housing & Service Plans are designed to facilitate the shortest possible shelter stays.
- **HMIS Use:** Provider has fully implemented the program in the local HMIS and actively participates in it.
- **Housing Focused Case Management:** Case management must include a housing plan and assist clients throughout their stay.
- **Housing First:** Client choice is prioritized in housing selection and supportive service participation.
- **Governance:** At least one current or former homeless individual serves on the board of directors.

STANDARDS FOR EMERGENCY/TEMPORARY HOUSING

SUGGESTED PRACTICE

SYSTEM RECOMMENDATIONS

Approaches

- Adopt a client-centered, strengths-based approach to case management (e.g., motivational interviewing)
- Employ a harm reduction model, along with trauma-informed care.
- Update IHSPs over time, in recognition of the fact that a traumatized guest may not fully engage for 2 to 3 weeks.
- When possible, establish contact & ensure continuity of care with new case manager.
- When making permanent housing placements, provide orientation to the neighborhood & ensure connections with contacts & resources.
- Upon exit to permanent housing, provide a care kit & household items.
- Plan meals that adhere to or exceed USDA's Dietary Guidelines.
- Focus on building meaningful connections with clients that eases the process of transitioning into housing and also complements prior relationships with any outreach staff / Housing Navigators.

Staffing

- Employ multilingual staff.
- Ensure that all staff are culturally competent & -sensitive.
- Employ multi-disciplinary team or partnership, including housing specialists who locate housing & navigate application processes.
- Train on emergency health response, secondary trauma, CPR, & communicable diseases.
- Test for TB annually & on occasions of exposure.

Tracking

- Monitor retention outcomes frequently.
- Utilize alumni for follow-up & tracking.
- Follow up immediately after placement.

Data

- Utilize VI-SPDAT to determine chronically homeless status for guests.
- Adjust consent protocols & improve HMIS participation to allow tracking of recidivism & follow-up of past guests.

Housing

- Fund housing locators & navigators to allow for more seamless connections between shelters & permanent housing.
- Fund flexible move-in accounts to offset costs of security deposit/first-last, utility turn-on fees, & moving costs.
- Establish a furniture bank with hot boxes for permanent housing move-ins.

Processes

- Funding and resources should be utilized to support a coordinated entry system that quickly connects people to housing, is built on effective partnerships that enhance service capacity and promote housing retention and community integration.
- Establish an independent party for grievances to support equity, safety, and security, and to administer customer satisfaction surveys.
- Improve benefits application & receipt processes, including SSI processes.

STANDARDS FOR SUPPORTIVE HOUSING



GOALS & INDICATORS

Assessment

75% maintain housing 3 months after program exit

35% increase income by program exit (through earned income or non-cash benefits [60% PSH])

Length of Stay

50% exit shelter/temporary into housing program within 120 days of CE enrollment

Housing Navigation

85% exit to permanent housing destinations

Guest Satisfaction

85% of those who complete the program would recommend the agency to someone else in need

OPERATING STANDARDS

- **Housing Focused Case Management:** Case management must include a housing plan and assist clients throughout their stay.
- **Case Conferencing** Case conferencing solves problems in moving people towards housing more quickly and effectively. Should include HPL data updates and a focus on improvements or needed coordination to support clients moving to the next step towards housing who are “stuck” or “lost” at different phases of the housing process and need additional support or coordination to move forward.
- **Wrap-Around Services:** 1) Easy access to a comprehensive array of services designed to assist tenants in sustaining stability and productive lives in the community. 2) At a minimum, service coordination and case management must be offered to every client.
- **Access to Housing:** To receive financial assistance, clients cannot be required to have completed a program, have had a shelter stay, be clean and sober, medical compliant, or have a clean housing / credit / evictions history.
- **Housing First:** Client choice is prioritized in housing selection and supportive service participation.
- **Prioritization:** Prioritize most vulnerable households according to *Denton County Coordinated Entry System Policies and Procedures Manual*.
- **Diversion:** When program housing resources are limited, staff attempts diversion with households referred to their program.
- **Trauma-Informed Care:** understand, recognize and respond to effects of all types of trauma clients may have experienced, and avoid re-traumatization via program requirements (ie. SAMHSA).
- **Income:** All guests are assisted in receiving all eligible benefits (at minimum SNAP, SSI, SSDI, VA) &/or achieving earned income.
- **HMIS Use:** Provider has fully implemented the program in HMIS and actively participates in it.

STANDARDS FOR SUPPORTIVE HOUSING

SUGGESTED PRACTICE

SYSTEM RECOMMENDATIONS

Approaches

- Adopt a client-centered, strengths-based approach to case management with services that are flexible and tenant based, including mental health, substance abuse treatment, life skills, legal assistance and/or employment education/training/job placement.
- Employ a harm reduction model, along with trauma-informed care.
- Prioritize the most vulnerable households according to the Denton County Coordinated Entry system and the Housing Priority List.
- Transparent leasing standards that focus on the hardest to serve. (highest barriers)
- Client choice should be prioritized in housing selection and supportive service participation.
- Utilize available community resources to overcome barriers. ie. Fair Market Rent (FMR).
- Consistent relationship management with landlords is an effective tool for client advocacy and housing stability.
- Every participant should have a housing retention plan and in PSH options should be made available to clients for independent living situations.
- Tenants in danger of eviction can be assisted with finding other suitable permanent housing.

Staffing

- Employ multilingual staff.
- Ensure that all staff are culturally competent & -sensitive.
- Employ multi-disciplinary team or partnership, including housing specialists who locate housing & navigate application processes.
- Case management/services coordination in supportive housing should be staffed at a minimum ratio of 1:30 and in PSH 1:15 for singles; 1:10 for families.

Tracking

- Monitor retention outcomes frequently.
- Follow up intervals at three and six months after placement.

Partnerships

- Creation & maintenance of effective partnerships with other service providers, whether by choice or necessity; ones that complement each program's approaches, that will lead to transitions that most benefit clients, and that encourages continued engagement and follow-up afterwards.

Data

- Utilize Denton County Coordinated Entry system and the Housing Priority List to ensure the most vulnerable households are prioritized.
- Improve HMIS participation to allow tracking of recidivism & follow-up of past clients.

Housing

- Fund housing locators & navigators to allow for more seamless connections between shelters & permanent housing.
- Fund flexible move-in accounts to offset costs of security deposit/first-last, utility turn-on fees, & moving costs.
- Increase a diverse and accessible housing stock for 0%, 30% and 60% or Area Median Income (AMI)
- Establish a furniture bank with housing supply boxes for permanent housing move-ins.

Processes

- Standards should increase success and expand permanent supportive housing.
- Establish an independent party for grievances to support equity, safety, and security, and to administer customer satisfaction surveys.
- Improve benefits application & receipt processes, including SSI processes.

Funding

- Funding and resources should be utilized to support Denton County Coordinated Entry system and the Housing Priority List that quickly connects people to housing, is built on effective partnerships that enhance service capacity and promote housing retention and community integration.
- Funding should match needs for services (e.g., funding for chronic homeless populations should provide sufficient funding of services needed for the population; \$2,500-\$15,000/-year/resident).
- Funding and resources should be utilized to support a coordinated entry system that quickly connects people to housing, is built on effective partnerships that enhance service capacity and promote housing retention and community integration.

GLOSSARY OF COMMON TERMS

A

ADA: The Americans with Disability Act of 1990 prohibits discrimination based on disability and requires programs to take reasonable steps to make programs accessible to people with disabilities.

Affordable housing: A general term applied to public- and private-sector efforts to help low and moderate-income people purchase or lease housing. As defined by the United States Department of Housing and Urban Development, any housing accommodation for which a tenant household pays 30% or less of its adjusted gross income.

Anchor Identification: The practice of identifying street homeless individuals who consistently reside in a specific geographic area with the hope that once an “anchor” is successfully housed the other homeless individuals in the area will be willing to engage in services and housing.

B

Boundaries: In homeless programs, “boundaries” refers to limits to physical, mental, and emotional client-staff interactions to ensure that the rights and interests of clients are respected and that staff work reflects the agency’s ethical values.

C

Case management: The overall coordination of an individual’s treatment plan and use of services, which may include medical and mental health services, substance use services, and vocational training and employment. Although the definition of case management varies with local requirements and staff roles, a case manager often

assumes responsibilities for outreach, advocacy, treatment planning and referral on behalf of individual clients.

Chronically Homeless: HUD defines chronically homeless as a person or family (head of household) who has been homeless and living or residing in a place not meant for human habitation, a safe haven, or emergency shelter for at least a year or at least four separate occasions in the last 3 years and who can be diagnosed with a disabling condition.

Contacts: In outreach programs, conversations with homeless persons.

Continuum of Care: As a condition of funding, HUD requires local communities establish “Continuum of Care” to oversee community planning around homelessness. Continuum of Care and Continuum are defined to mean the group that is organized to oversee community planning and carry out the responsibilities required to address homelessness within a specified geographic area. The Continuum is composed of representatives from various stakeholders from throughout the community.

Coordinated Entry System (CES): A system by which those experiencing homelessness and housing resources find each other in the most efficient way possible. The four main components include: Access (street outreach), Assessment, Assistance (housing navigation), Assignment.

D

DHA: Denton Housing Authority

Diversion: Helping people seeking shelter by identifying immediate alternate housing and connecting

them with services and financial assistance to help them to return immediately to permanent housing. An emerging best practice, diversion programs can reduce the number of individuals and families becoming homeless, and thus the demand for shelter beds.

E

Emergency / Crisis / Bridge Housing: A facility providing temporary or transitional shelter for the homeless, sometimes for sub-populations of the homeless

Encounter: A street outreach worker’s interaction(s) with a homeless person that does not result in the provision of a service, a client assessment, or the beginning of a case plan.

Engagement: A street outreach worker’s interaction(s) with a homeless person resulting in a client assessment or the beginning of a case plan.

Entitlements: Publicly funded financial and medical benefits available to individuals who meet criteria usually based upon income or disability measures.

F, G, H

Harm reduction: Harm reduction is a set of practical strategies that reduce the negative consequences associated with drug use, including safer use, managed use, and non-punitive abstinence.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, which includes requirements for confidentiality of health care information, which are often cited as barriers to coordinated care.

Homeless Management Information System (HMIS): A

community-wide database congressionally mandated for all programs funded through the Department of Housing and Urban Development (HUD) homeless assistance grants. It is a software application designed to record and store client-level information on the characteristics and service needs of homeless persons. An HMIS is typically a web-based software application that homeless assistance providers use to coordinate care, manage their operations, and better serve their clients.

Hot Box: A heated box used to eradicate bed bugs in exposed furniture.

Housing First: The goal of "housing first" is to immediately house people who are homeless. Permanent housing is provided as quickly as possible no matter what is going on in one's life, and the housing is flexible and independent so that people are provided permanent housing easily and have access to sufficient supportive services to stay housed. Housing first can be contrasted with a continuum of housing "readiness," which typically subordinates access to permanent housing to other requirements.

Housing Navigator: is a person primarily responsible for ensuring a client's successful transition from street to home, whose duties can include, but is not limited to: reaching out to housing providers, preparing and collecting required documents, facilitating housing placement, and acting as a point of contact for landlords, property managers and clients throughout the transition and service provision process.

Housing Retention Plan: is a plan developed and agreed to by social services staff, property management staff, and tenant that seeks to mitigate disruptive

behaviors or resolve health and safety conditions, and / or financial issues that violate lease agreement and / or house rules and threaten tenancy.

HUD: Department of Housing and Urban Development

I

Individualized Housing & Service Plan (IHSP): A service plan created by case managers for homeless clients to assist them in addressing barriers and maintaining stability.

Intake: Recordation of basic client data into a database upon entry into a program (e.g., capturing and loading required data to HMIS upon entry to emergency shelter).

Interim Housing: Sometimes referred to as "bridge housing"; temporary housing including emergency shelters, safe havens, transitional housing, and short-term hotel or motel vouchers. Provides temporary shelter during transition to permanent housing.

M

Master leasing: A legal contract in which a third party (other than the actual tenant) enters into a lease agreement with the property owner and is responsible for tenant selection and collection of rental payments from sub-lessees (see sublease).

Motivational Interviewing: A clinical approach that emphasizes a collaborative therapeutic relationship in which the clinician "draws out" the client's own motivations and skills for change, thereby empowering the client.

MOU: Memorandum of Understanding

N

Next-Step Housing: Appropriate destinations for persons transitioning from nonpermanent housing locations. The Standards of Excellence employ the same successful destinations as LAHSA for households exiting emergency shelters, which are: transitional housing, permanent supportive housing, substance abuse treatment facility or detox center, rental by client (no ongoing subsidy), owned by client (no ongoing subsidy), safe haven, rental by client (with ongoing housing subsidy), owned by client (with ongoing housing subsidy), staying or living with family or friends (permanent tenure), and deceased.

O

Outcome: A measure of the result of a system, relative to its aim, often used to measure the success of a system. (N.B. "Outcomes" measure system success, while "outputs" measure activity.)

Output: The quantity of goods and services produced (e.g., the number of people served)

P

Permanent Housing: Housing that is governed by a lease with no limits on length of stay. In terms of housing placement goals, the permanent housing category includes permanent supportive housing, rental by client (no ongoing subsidy), owned by client (no ongoing subsidy), rental by client (with ongoing housing subsidy), owned by client (with ongoing housing subsidy), and staying or living with family or friends (permanent tenure).

Permanent Supportive Housing: Affordable housing where the tenant pays no more than 30 to 40 percent of their income for housing costs. The tenants have a lease and there is an indefinite length of

stay as long as the tenant complies with lease requirements. Tenants should have easy access to a comprehensive array of individualized and flexible services, either on-site or in proximity to the housing site, that are designed to assist tenants in sustaining stability and productive lives in the community.

Point in Time (PIT) Count: A HUD-mandated count of the sheltered and unsheltered homeless population in a community, administered at least biennially within each continuum of care.

Q, R

Rapid Re-Housing: Promptly housing individuals or families who become homeless, often through temporary assistance to obtain and retain housing.

Recidivism: In homeless programs, "recidivism" refers to a return to homelessness after moving into permanent housing, as documented by HMIS.

S

Scattered-site housing: Dwelling units in apartments or homes spread throughout a neighborhood or community that are designated for specific populations, usually accompanied by supportive services.

Service Coordination: the activity of identifying and arranging for the provision of mainstream, community-based services and resources for the tenants within a given building or project. These services are supplementary to the core case management and housing support services of a permanent supportive housing project.

Single-site housing: A housing program in which all living units are located in a single building or complex.

SSDI (Social Security Disability Income): Cash benefits for people with disabilities who have made payroll contributions to the federal social security program while they were employed.

SSI (Supplemental Security Income): Federal cash benefits for people aged 65 and over, the blind or disabled. Benefits are based upon income and living arrangement.

SSN: Social Security Number

Successful Destinations: The Standards of Excellence employ the same successful destinations as LAHSA for households exiting outreach programs, which are: emergency shelter, including hotel/motel with emergency shelter voucher, transitional housing, permanent supportive housing, substance abuse treatment facility or detox center, rental by client (no ongoing subsidy), owned by client (no ongoing subsidy), hotel or motel paid by client, safe haven, rental by client (with ongoing housing subsidy), owned by client (with ongoing housing subsidy), staying or living with family or friends (permanent tenure), and deceased.

T

Tenancy obligations: Minimum requirements to be a tenant in good standing, such as payment of rent, following house rules, maintaining a healthy and safe living unit, and meeting other lease requirements.

Tenant: A person who resides in rented premises under the terms of a lease. Tenants of supportive housing should have the same rights and responsibilities as tenants of other lease-based, permanent housing.

Transitional Housing: Time-limited housing meant to help homeless people access permanent housing,

usually within two years, through the provision of intensive supportive services.

U, V

Voluntary Services: The term "supportive" in supportive housing refers to voluntary, flexible services designed primarily to help tenants maintain housing. Voluntary services are those that are available to but not demanded of tenants, such as service coordination/case management, physical and mental health, substance use management and recovery support, job training, literacy and education, youth and children's programs, and money management.

W, X, Y, Z

Warm Hand-Off: The transfer of a client from one provider to another, typically with a face-to-face introduction, to confer the trust and rapport the client has developed to the new provider. In homeless services, such transfers often occur between outreach workers and interim housing providers and between emergency shelter case managers and permanent supportive housing service coordinators. Many clinicians report that this face-to-face introduction helps ensure that the next appointment will be kept.



MAKING HOMELESSNESS RARE, BRIEF, AND NONRECURRING

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